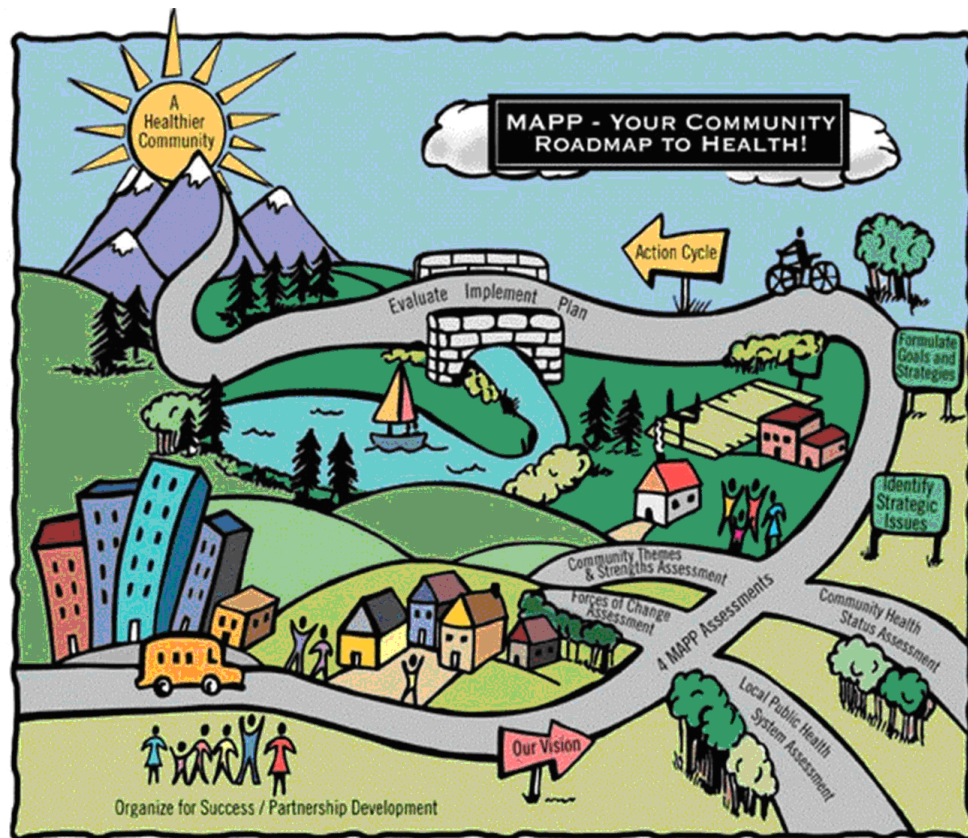


Community Health Assessment and Community Health Improvement Plan



2012

Duval County, Florida

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Executive Summary

The Duval County Community Health Improvement Plan (CHIP) was developed by diverse community organizations from different sectors with a goal of improving the health of Duval County residents. The CHIP is based on a common vision, community assessments, carefully chosen goals, and specific objectives developed to reach those goals. The four major goals of the CHIP are to increase access to health care, increase access to effective, efficient, and comprehensive mental health services, improve chronic care management, and enhance communication between the local public health system and the community.

The Mobilizing for Action through Planning and Partnerships (MAPP) model was used to facilitate the development of the CHIP. The MAPP process began with organizations within the community organizing themselves and preparing to implement MAPP. Next, these organizations created a unifying vision for better health in Duval County to guide the rest of the process. Then, assessments of the community's health status, community themes and strengths, the local public health system, and larger forces of change at work in Duval County were conducted. From these assessments, 13 strategic issues were identified and four community health priorities were chosen. Finally, a CHIP with objectives related to these priorities was developed.

These four community health priorities and the specific objectives for each priority resulted from the MAPP process:

1. Increase Access to Health Services

- a. Increase the proportion of Duval County residents who use electronic personal health management tools by 10% by December 31, 2013
- b. Increase the proportion of Duval County residents with health insurance to 90% by December 31, 2015
- c. Increase the number of primary care providers in the health care safety net in Duval County by 10% by December 31, 2015
- d. Increase the number of Partnership for a Healthier Duval member organizations that include a social determinant of health objective in their strategic plan by 25% by December 31, 2013

2. Increase Access to Mental Health Services

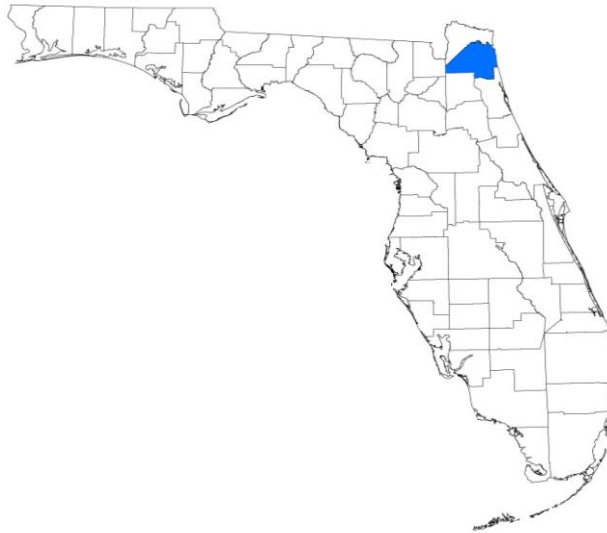
- a. Increase the proportion of primary care facilities that provide mental health treatment by 10% by December 31, 2015
- b. Decrease the number of poor mental health days experienced by adults by 10% by December 31, 2015

3. Improve Chronic Care Management
 - a. Decrease percentage of emergency room visits due to ambulatory care sensitive conditions by 10% by December 31, 2015
 - b. Establish coordinated system for chronic care management and expansion clearinghouse by December 31, 2015
 - c. Increase the proportion of persons with a usual primary care provider to 90% by December 31, 2017
4. Enhance Communication within the Local Public Health System
 - a. Create and communicate a formalized health system process to ensure continuity of care for Duval County residents by December 31, 2015
 - b. Create a dashboard to track progress towards meeting CHIP objectives by December 31, 2013
 - c. Increase the number of member organizations in the Partnership for a Healthier Duval from outside the health sector by 10% by December 31, 2013

Duval County Background

Duval County is a consolidated city-county government located on the northeast coast of Florida and includes the cities of Jacksonville, Baldwin, and the beach communities of Jacksonville Beach, Neptune Beach and Atlantic Beach. Jacksonville is the largest city geographically in the contiguous forty-eight states and Duval County has a land area of over 800 square miles. In 2010, there were 864,263 residents in Duval County according to the US Census.

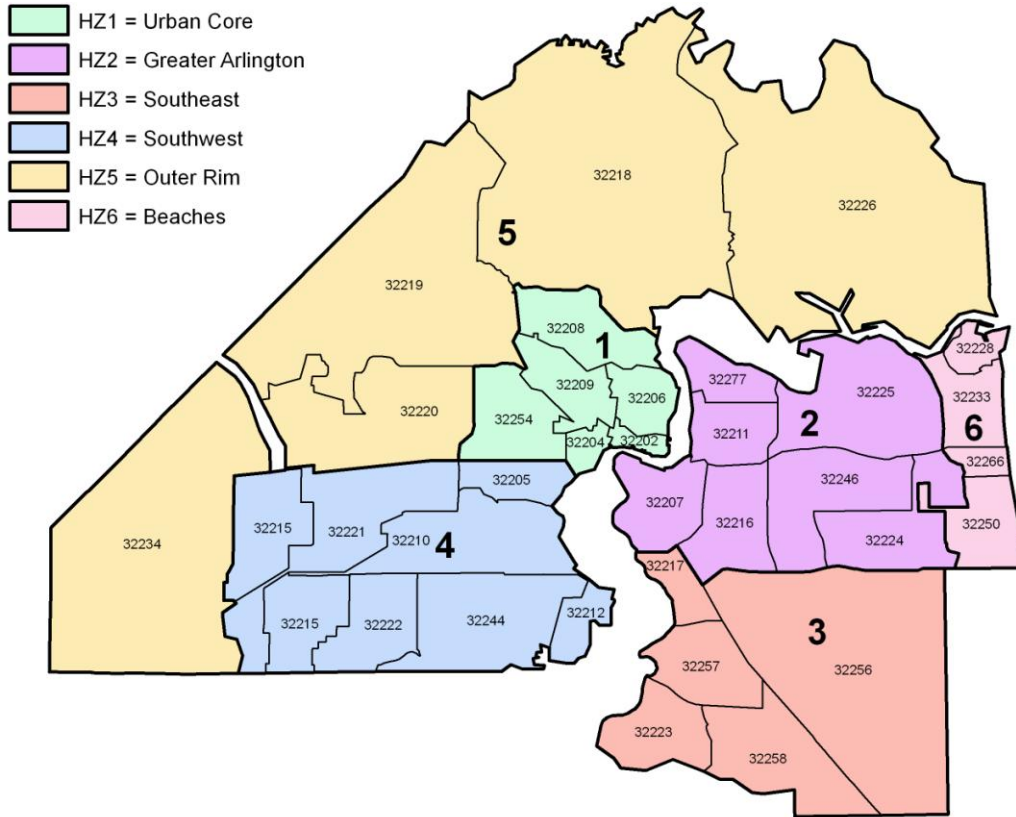
Figure 1: Florida Counties Map



Duval County is comprised of urban, suburban and pockets of rural areas. The county is divided into six health zones (HZ) which differ demographically and economically and consistently showed large health disparities in the Community Health Status Assessment. These six health zones are shown below in Figure 2.

Duval County's population is 61% white, 29% black, and 10% other races with more than 7% of the population having Hispanic ethnicity. HZ1 has the largest percentage of minority population (81%), while only 16.0% of the residents of HZ6 are minorities. For blacks in Duval County, 34% live in HZ1 while only 6% live in HZ3 and 2% live in HZ6. Hispanics are located primarily in HZ2 (41% of all Hispanics in Duval County), HZ4 (23%), and HZ3 (19%).

Figure 2: Duval County by Health Zone



Socio-economic status also varies greatly in Duval County with 16.6% of residents living below the poverty level. Blacks are more likely to live in poverty (27.2%) than whites (11.2%) according to the 2010 American Community Survey (ACS). Hispanics also live below poverty level more often (18.6%) than the Duval County average. The highest poverty rates are seen in HZ1 (29.6%) while the lowest rates are in HZ3 (9.5%).

Wide gaps in educational attainment also exist within Duval County. Overall, 12.2% of adults aged 25 and older are not high school graduates. About 23% of the Hispanics and 16% of blacks have less than a high school education compared with only 10% of whites. HZ1 has the lowest percentage of population with more than a high school education (35.7%) while HZ2, HZ3, and HZ6 all have more than 60% of their residents who have attained more than a high school diploma.

Chronic diseases are impacting Duval County residents at alarming rates. In 2010, more people died from cancer than from any other disease, followed by heart disease, chronic obstructive pulmonary disease, stroke, and diabetes. For each of these diseases, death rates were higher for blacks than for whites. HZ1 had the highest total death rate at 1104 deaths per 100,000 residents when adjusted for age differences in the population while HZ3 had the lowest rate at 743 deaths per 100,000 residents.

Many diseases, including all of the leading diseases mentioned above, are associated with obesity, poor nutrition, lack of exercise, and other behavioral and lifestyle factors. The Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS) were both instituted by the Centers for Disease Control and Prevention (CDC) to monitor these and other health risk factors in the adult population and in middle and high school populations, respectively. The Florida Department of Health, with technical assistance from the CDC, collected county level BRFSS data in 2007 and 2010. YRBS was conducted in the Duval County school districts in 2009 and 2011 with more students sampled in 2011 to create reliable sub-county level estimates through funding from the CDC.

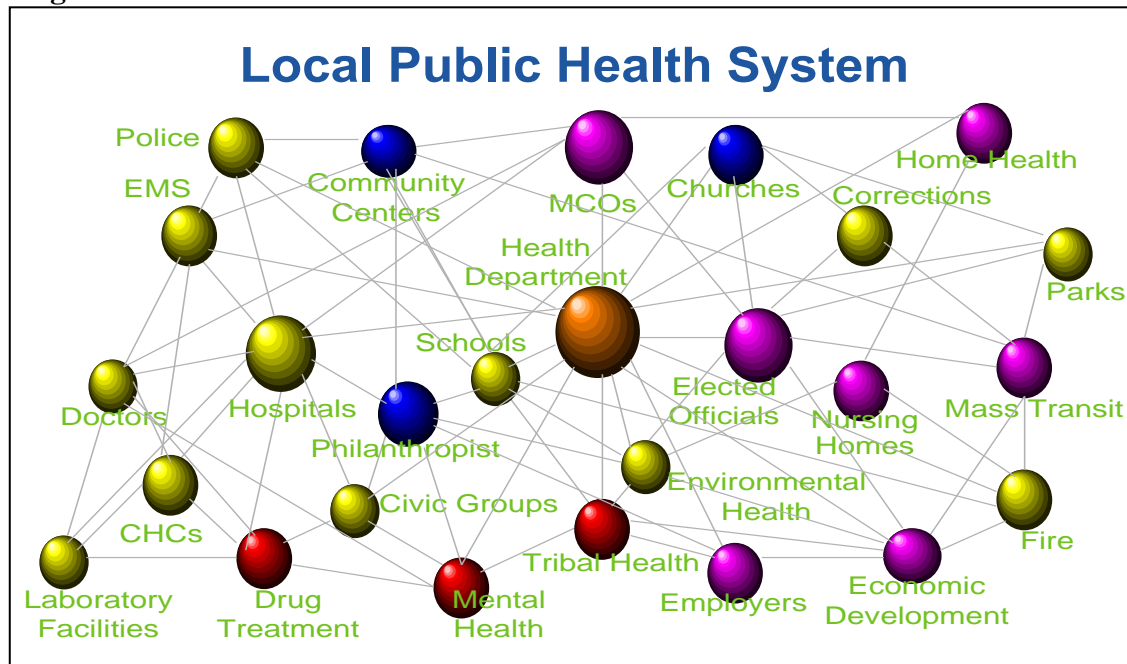
Obesity is a nationwide problem that has grown significantly in recent years. Nationally, the BRFSS reports that only 15.9% of adults were obese in 1995 but 27.6% of adults were considered obese in 2010. Duval County was above the national average, with 28.4% of adults considered obese. An additional 36.0% of adults are considered overweight as well. There are great racial disparities among adults who are obese or overweight, with 64.6% of whites and 79.0% of blacks in these high-risk categories. Only 32.0% of adults met moderate physical activity guidelines in 2007, while 23.5% of adults did not generally participate in physical activities. During the same time period, 23.9% of adults reported consuming at least 5 servings of fruits and vegetables a day. While 24.1% of whites and 24.6% of blacks met this nutrition requirement, 18.2% of Hispanics in Duval County consumed the recommended amount of fruits and vegetables.

Obesity is a problem even among youth, where 11.9% of Duval County high school students were obese in 2011 and 22.0% of middle school students described themselves as slightly or very overweight. Both poor nutrition and lack of physical activity contribute to the obesity epidemic, and both were measured in several ways in the YRBS. In 2011, 80.4% of high schoolers and 87.0% of middle schoolers ate fruits and vegetables less than five times per day. Additionally, 26.1% of high schoolers drank a can of soda that wasn't diet at least once a day for the seven days before the survey date and 56.2% of middle schoolers said they drank soda at least once per day. The CDC recommends at least 60 minutes of physical activity a day at least 5 days a week for youth. Only 41.3% of Duval County middle schoolers and 30.7% of high schoolers met this requirement. The 2006 Jacksonville Evidence Based Policy Plan for the Prevention of Childhood Obesity highlights that between 1984 and 2007, Duval County students President's Challenge Physical Fitness Test results showed a steady decline, dropping from less than 50% to 30% of students meeting minimum standards. In contrast, 45.1% of middle schoolers and 41.1% of high schoolers reported watching 3 or more hours of television on the average school night.

Because of the complexity of the health problems and disparities described above, it is clear that solutions cannot be simplistic or ignore the multiple levels of factors leading to poor health. Geography, race, socio-economic status, education, disease, and risk factors are all interrelated and were considered throughout the MAPP process. It should also be observed that health care agencies are not the only organizations who are stakeholders in this issue, as health and these other factors cannot be separated. Public health is affected by many different factors on multiple levels as described by the following diagram. Health care workers, facilities, and agencies have a role, but counseling services, charitable and faith-based organizations, public

officials, public safety officers, employers, county infrastructure, and schools are just some of the other contributors to the health of residents of Duval County. It is essential to include community coalitions as partners in this effort to improve health for everyone in Duval County because public health problems and the contributing factors are so complex.

Figure 3: The Public Health Web



Duval County's public health system has had a successful history of building coalitions and delivering on grant funded opportunities in a wide variety of areas, including maternal and child health, nutrition, primary care, HIV/AIDS, environmental health, disaster preparedness, chronic disease prevention, and other core public health activities. This history has been particularly impressive since the local county health department currently receives little local tax support, and is one of two Florida counties currently barred from pursuing property tax millage to support community health services.

The Duval County Health Department's (DCHD) **Healthy Jacksonville** (Healthy Jax) is an example of community-based health coalition infrastructure, which was established in 2000 and is responsible for identifying community needs as they relate to health. Healthy Jax operates seven community-based coalitions that address the goals and objectives established in Healthy People 2010 and updated in Healthy People 2020. Three of these coalitions, the Childhood Obesity Prevention Coalition, the Nutrition and Physical Activity Coalition, and the First Coast Worksite Wellness Council, in collaboration with the Mayor's Council on Fitness and Well-Being, are responsible for engaging the community and city leaders in efforts to reduce overweight and obesity among children and adults in Duval County. Healthy Jax works collaboratively with three other local health councils, the School Health Advisory Council and the Duval County District Wellness Council, both associated with the Duval County Public School System, and the Governor's Council on Fitness to achieve fitness.

The **Childhood Obesity Prevention Coalition (COPC)**, established in 2003, is a consortium of community partners who work together to develop, implement and advocate for local strategies to reduce childhood obesity. In 2006, a COPC workgroup participated in a year-long effort to identify evidence-based strategies in the scientific literature to address childhood obesity prevention. The workgroup produced a set of policy recommendations that provided a foundation for COPC activities until 2008, when the COPC was funded (the Blue Foundation for a Healthy Florida, Embrace a Healthy Florida) to develop a resource guide and community action plan for childhood obesity prevention. The plan, “Healthy Kids, Healthy Jacksonville: A Community Call to Action to Reduce Childhood Obesity” outlines seven “calls to action” in specific spheres of influence, such as schools, city government, parents, etc. and proposes policy and environmental change strategies related to increasing access to healthy foods and active-living opportunities. Recently, the COPC made significant advances towards policy change related to active living through funding provided by the Blue Foundation and the Robert Wood Johnson Foundation-funded “Healthy Kids, Healthy Communities” grant. The COPC has partnered with the City of Jacksonville, Recreation and Community Services Department and Planning and Development Department. These offices have agreed to connect city resources/policies to the policy recommendations and activities of the COPC and this initiative.

The **Healthy Jacksonville Nutritional & Physical Fitness Coalition (NPFC)** is chaired by a registered dietician with the YMCA of Florida’s First Coast. This group has served as a catalyst for the development of many workplace-health-improvement initiatives in Jacksonville. Additionally, the group is currently developing an informational guide for restaurant owners to increase healthy food options, as well as one for consumers about how to make healthy food choices at restaurants. Additionally, the group is working to compile information about areas for safe and free outdoor physical activity in different parts of the city.

The **First Coast Worksite Wellness Council (FCWWC)** membership consists of local workplace wellness coordinators who meet to network, share resources, and collaborate to increase the number and quality of company-based wellness programs. Many companies in Jacksonville, such as the Jacksonville Electric Authority, City of Jacksonville, and Blue Cross and Blue Shield of Florida have large, nationally recognized wellness programs. Representatives from these companies provide leadership for the FCWWC and share their successes through mentoring relationships with companies whose wellness programs are in development.

The **Mayor’s Council on Fitness & Well-Being (MCFW)** includes members from local hospitals, universities, insurance providers, and others. Most are CEOs or top-ranking executives. In 2008, the MCFW and the FCWWC organized the Inaugural First Coast Worksite Wellness Conference, which featured national-level speakers. A task force also worked to implement an application process for the Jacksonville’s Healthiest 100 Award – a recognition effort to showcase successful wellness programs in Jacksonville.

Federal and state laws mandate the existence of wellness committees in public school districts and schools. The Duval County **School Health Advisory Council (SHAC)** facilitates the **Duval County Public Schools (DCPS) Wellness Committee**. These groups serve as the liaison to the county school board about health issues, including nutrition and physical activity.

The DCHD and Healthy Jax coalitions have successfully worked together and in collaboration with community leaders to implement broad-based policy, systems, and environmental change initiatives. In 2008, the contract for the DCPS food vendor was up for bid. The DCPS Wellness Committee and the Healthy Jacksonville COPC along with DCPS leadership advocated for the new contract to contain requirements for healthier options in school food service venues. As a result, the DCPS food vendor changed to a company that has agreed to work with DCHD and the community to restrict unhealthy food options and incorporate healthier options into Duval County's school food menus.

Other public health system collaborations include:

Embrace a Healthy Florida Initiative - The Blue Foundation for a Healthy Florida addresses the causes of childhood obesity with Embrace a Healthy Florida, a statewide initiative that goes beyond traditional nutrition and fitness programs. Embrace a Healthy Florida provides grants to nonprofit organizations, funds research, and fosters community collaboration and engagement.

Immunization Task Force - The Immunization Task Force provides an opportunity for various stakeholders to actively collaborate to ensure consistent messages are being disseminated throughout Duval County regarding vaccine-preventable diseases.

Federal Qualified Health Centers – Duval County has a thriving Federally Qualified Health Center network which currently operates five clinics, one mobile medical van, and one mobile dental van. In addition, the network provides pediatric, family practice and on-site pharmacy services.

Infant Mortality – The Northeast Florida Healthy Start Coalition, Inc. oversees multiple community coalitions and initiatives aimed at eliminating inequities in maternal and infant health. Working with the Chartrand Foundation and other local funding sources, the group is addressing social determinants through its “Make a Noise! Make a difference!” advocacy and community capacity building initiative.

Jacksonville Journey – The goal of this comprehensive community-wide anti-crime initiative is to achieve peace and prosperity in every home on every street for every citizen through various crime prevention programs and policies. The initiative ranges from after-school programs and capital investments to additional police, correctional, and communication officers.

Youth Risk Behavior Survey - The Youth Risk Behavior Survey (YRBS) is a self-administered, anonymous survey conducted in high schools and middle schools in Duval County during the spring of 2009 and 2011. The survey covers four general health risk areas: (1) violence, suicide, and safety; (2) alcohol, tobacco, and other drug use; (3) sexual behaviors; and (4) physical activity and dietary behaviors.

Asthma Partnership - Nemours partners with the Jacksonville community to produce a comprehensive pediatric asthma care program that incorporates teaching children and families

about the disease with clinical programs developed by health professionals in both pulmonary medicine and allergy/immunology. The program attracts some of the best children's asthma and allergy specialists that service the needs of the most vulnerable.

MAPP Process Overview

Improving health is a shared responsibility not only of health care providers and public health officials, but also of a variety of other actors in the community who contribute to the well-being of individuals and populations. The MAPP process is a community-owned approach to strengthening the local health system by building on previous experiences through strategic planning. Bringing community groups together enables all participants to collaborate, maximize resources, and avoid replication of effort and funding. Building capacity in local organizations and within the community itself by increasing the skills, resources, and infrastructure available to them is a key part of MAPP.

Figure 4: MAPP Overview



The MAPP process consists of 6 phases outlined below:

- **Phase 1: Organize for Success/Partnership Development**
Lead organizations begin planning the MAPP process and enlisting other community organizations to participate in the process.
- **Phase 2: Visioning**
The community develops a shared vision for Duval County and common values to determine an ideal end point for the MAPP process.
- **Phase 3: The Four MAPP Assessments**
These assessments take in-depth looks at the community, its health system and outcomes, and larger forces at work in Duval County.
 - **Forces of Change Assessment**
The impact of forces such as legislation and technology that affect the context of the community is evaluated.
 - **Local Public Health System Performance Assessment**
A comprehensive assessment considers organizations from across multiple sectors and their contribution to the public's health.
 - **Community Themes and Strengths Assessment**
This assessment looks at issues residents feel are important and the assets the community possesses to address those issues.
 - **Community Health Status Assessment**
This evaluation investigates health outcomes and quality of life at a detailed level.
- **Phase 4: Identify Strategic Issues**
This phase takes all the data from the four assessments and identifies the most critical issues that must be addressed for Duval County to achieve its vision.
- **Phase 5: Formulating Goals and Strategies**
After identifying a list of strategic issues, broader goals addressing these issues are created and specific strategies to meet these goals are developed.
- **Phase 6: Action Cycle**
Strategies are planned, implemented, and evaluated in a continuous cycle which celebrates successes and adapts to new challenges.

Phase 1: Organize for Success/Partnership Development

The first phase of the MAPP process includes organizing the planning process and developing partnerships with the organizations that will participate. This phase helps the MAPP Core Team and participants to understand activities to be completed, time required, and expected results.

The Partnership for a Healthier Duval is a team of leaders, citizens and interested individuals that provide health services or are interested in improving the health of Duval County. Using the MAPP Strategic Health Planning Tool, the Partnership worked together to draft a plan to improve the health of Duval County residents using feedback from residents, health providers and other interested partners.

In February 2008, DCHD and the Partnership for a Healthier Duval convened the MAPP kickoff meeting. More than 300 community members and stakeholders were invited to participate. Critical partners included the City of Jacksonville Mayor's Office, the City of Jacksonville Planning and Development Department, Duval County Public Schools, local health coalitions, churches, community organizations, hospitals and clinics. Approximately 150 participants attended the initial meeting. A list of represented organizations is included in Appendix A.

During the meeting, working groups were provided an overview of the MAPP model and the intended planning process. Short-term goals of the planning process included selecting a Core Support Team, organizing participants, conducting a MAPP Readiness Assessment and managing the ongoing process.

Phase 2: Visioning

One of the first steps in this collaborative process is the development of a vision for Duval County. A community's vision statement provides a target based on shared values, principles, and beliefs that focuses and directs the remainder of the MAPP process. Formulating a vision begins with answering the following questions:

- What does a healthy Duval County mean to you?
- What are the important characteristics of a healthy community for all who live, work, and play here?
- How do you envision the local public health system in the next 5 or 10 years?

The process began with a small task force consisting of the MAPP core Leadership Team and other community partners formulating a vision statement based on the outcomes of the first general MAPP meeting. The charge for this small task force was to develop a vision that was strong, powerful, and represented the ideal future of Duval County. In addition, the statement needed to possess the impetus to mobilize and energize many diverse organizations and individuals. With these characteristics in mind, the task force formulated a statement that encompassed the vision and values for the ideal future of Duval County.

The Partnership for a Healthier Duval then finalized the visioning process at a January 13, 2009 meeting with over 80 community partners in attendance. Minor adjustments were made through group consensus which led to a statement that is strong, powerful and represents the ideal future of all Duval County residents.

Vision

The Partnership for a Healthier Duval envisions a community of empowered and informed individuals with optimal emotional, physical and mental health supported by an integrated, accessible and inclusive health system founded on the values of compassion, respect, and equality for all Duval County residents.

Figure 5: The Visioning Meeting



Phase 3: The Four MAPP Assessments

Phase 3 of the MAPP process is designed to collect large amounts of data across a variety of sectors. Four assessments of the data are conducted in an attempt to capture the current status and future challenges of the community. By examining these assessments, identifying issues, developing goals, planning strategies, and executing actions, the MAPP process aims to reduce any problems captured by the assessments.

Forces of Change Assessment

The Forces of Change Assessment is used in the MAPP health planning process to answer the following questions:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

This assessment results in a comprehensive, focused list that identifies key forces and describes their impact. The forces identified are broad categories that include trends, events and factors.

- Trends are patterns over time such as migration in and out of a community or a growing disillusionment with governments.
- Factors are discrete elements such as a community's large ethnic population, an urban setting or the jurisdiction's proximity to a major waterway.
- Events are one-time occurrences such as a hospital closure, a natural disaster or the passage of new legislation.

The Partnership for a Healthier Duval's core planning team used the National Association of City and County Health Officials (NACCHO) MAPP planning manual to design the forces of change discussion. A pre-meeting worksheet was distributed to all members of the Partnership for a Healthier Duval in March 2009 and member feedback was compiled and used to guide the in-person discussion in April 2009. The pre-meeting worksheet asked all members to identify their top forces of change.

These forces were then categorized into themes and prioritized by the overall membership during the in-person meeting using a multi-voting technique. Each member received 5 "votes" to assign to their top five forces of change. Four facilitators were chosen from the membership to lead groups in an in-depth discussion of the identified forces prioritized by members. The discussion allowed members to discuss the potential opportunities and threats of each force. The detailed list of potential opportunities and threats was recorded by each group.

The lists of forces chosen are shown below in order of priority by category and then by topic within each category. Only forces that received votes in the prioritization activity are listed.

Health Forces: Access & Insurance

- Loss of health insurance and increasing number of uninsured
- Lack of prevention funding
- Use of emergency room as primary care
- Lack of dental coverage for all residents
- National health insurance reform
- Lack of assisted living beds and increased need
- Access for special populations

Economic Forces

- Economic downturn
- Job Loss/Unemployment/Lack of Job Opportunities
- State and local funding cuts
- Stimulus bill and associated funding

Education & Youth Forces

- Loss of physical education classes
- Decreased graduation rates
- Budget cuts
- Reduced number of school nurses

Development Forces: Land Use

- Poor walkability of the city
- Mixed land-use development
- Designated places to walk
- Empty strip malls/shopping centers

Lifestyle/Behavior Forces

- High rates of obesity and chronic disease
- Rising cost of prescription drugs combined with insurance loss
- Rising obesity rates – food banks not well stocked and high in fat & calories
- Individuals with communicable disease that are non-compliant with medications and further spread disease

Mental Health & Substance Abuse Forces

- Limited mental health services
- Discrimination against people with mental health issues and failure to address as public health concern
- Limited prevention initiatives
- Prescription drug abuse

Government/Political/Advocacy Forces

- High US healthcare costs
- Increasing government control of healthcare

- Health care providers who do not survive price controls and cuts
- Distrust of system/government
- Decreasing state and local revenue – impact on health programs/priority
- Local politics
- Government and administration of school system

Health Awareness & Communication Forces

- Need to promote physical activity
- Health Literacy
- Inaccurate information on medical issues

Crime & Violence Forces

- Prevalence of crime/homicides
- Jacksonville Journey Initiative

Population Forces

- Increasing aging population
- Increase in immigrant/undocumented population
- Affordable housing

Transportation Forces

- Poor public/mass transit/size of city
- Need for healthcare providers to work with JTA to provide efficient services

Technology Forces

- Electronic medical record/federal connection
- Health information technology

Social Service Forces

- Increased numbers of homeless persons – children becoming large majority
- Local budget program cuts

Development Forces: Environmental

- Global warming
- Air/Water pollution

Emergency Preparedness/Disaster Forces

- Is Duval ready if a pandemic comes?
- Natural disaster threats

Miscellaneous/Other Forces

- Complacency is Jacksonville's biggest challenge on any issue

Partnership/Collaboration Forces

- Jacksonville capable of collaboration, needs strong lead

Local Public Health System Performance Assessment

In order to perform a Local Public Health System Performance Assessment (LPHSPA), the Partnership for a Healthier Duval selected a proven national assessment instrument called the National Public Health Performance Standards Program (NPHPSP). This assessment seeks to answer the questions:

- What are the activities and capacities of our public health system?
- How well are we providing the 10 Essential Public Health Services in our jurisdiction?

The dialogue that occurs in answering these questions can help to identify strengths and weaknesses and determine opportunities for improvement.

Any organization or entity that contributes to the health or well-being of the Duval County community is considered part of the public health system. By sharing their diverse perspectives, all participants gained a better understanding of each organization's contributions, the interconnectedness of activities, and how the public health system can be strengthened.

Participants from throughout the Duval County Public Health System discussed and determined how they are performing compared to each of the standards through this assessment. Performance scores were generated for each of the ten essential public health services.

Figure 6: Duval County Performance Scores by Essential Public Health Service

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Figure 7: Duval County Performance Scores for Each Essential Service Error! Not a valid link.

Performance scores for each essential service calculated based on what percentage of NPHPSP standards were met in each category. They were then ranked and categorized as optimally meeting performance standards (75% or more compliance), significantly meeting performance standards (50% - 75% compliance), moderately meeting performance standards (25% - 50%), or minimally meeting performance standards (less than 25% compliance).

Figure 8: Percentage of Essential Services by Progress Towards Meeting Performance Standards

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The challenge of preventing illness and improving health is ongoing and complex. The ability to meet this challenge rests on the capacity and performance of a thriving public health system. Public health performance standards are intended to guide the development of stronger public health systems capable of improving the health of populations. Through periodic assessment guided by model performance standards, public health leaders can improve collaboration and integration among the many components of a public health system, more effectively and efficiently use resources, and improve health intervention services.

Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment provides a deep understanding of the issues that residents feel are important by answering the following questions:

- What is important to our community?
- How is quality of life perceived in our community?
- What assets do we have that can be used to improve community health?"

During this assessment, community thoughts, opinions, concerns, and solutions are gathered as well as feedback about the quality of life in the community and community assets.

Listening to and communicating with the community are essential to any communitywide initiative. The impressions and thoughts of community residents can help pinpoint important issues and highlight possible solutions. Additionally, every participant feels like an integral part of the process and believes their concerns are heard. Mobilizing and engaging the community may be a daunting task, but when successful, it ensures greater sustainability and enthusiasm for the process.

The Partnership for a Healthier Duval's core planning team used the NACCHO MAPP planning manual and examples from other Florida communities to design the Community Themes and Strengths Survey. The survey is available in Appendix B. Paper surveys were issued to community partners and residents and electronic surveys were sent for them to share with others within their organizations. Of the 1,209 surveys that were returned, 1,097 (90.7%) were completed.

Figure 9: Demographic Breakdown of Survey Respondents Error! Not a valid link.

County Sources: 1. United States Census, 2010

2. American Community Survey 2010 1-year estimates

* Did Not Answer - Survey responses may not add to 100% due to respondents not answering all questions

One goal for the Community Themes and Strengths Assessment was to survey 1,000 Duval County residents with demographic characteristics similar to the population of the entire county. Highlighted rows in Figure 9 for ages 64+, males, and females represent areas where the sample proportion differs significantly from the county population. Other communities conducting MAPP assessments report similar female-skewed data. The lack of response from community members over 64 years of age is also noteworthy.

Figure 10: Survey Responses to Single Response Questions
(The sum of the percentages for all choices for each question add to 100%)

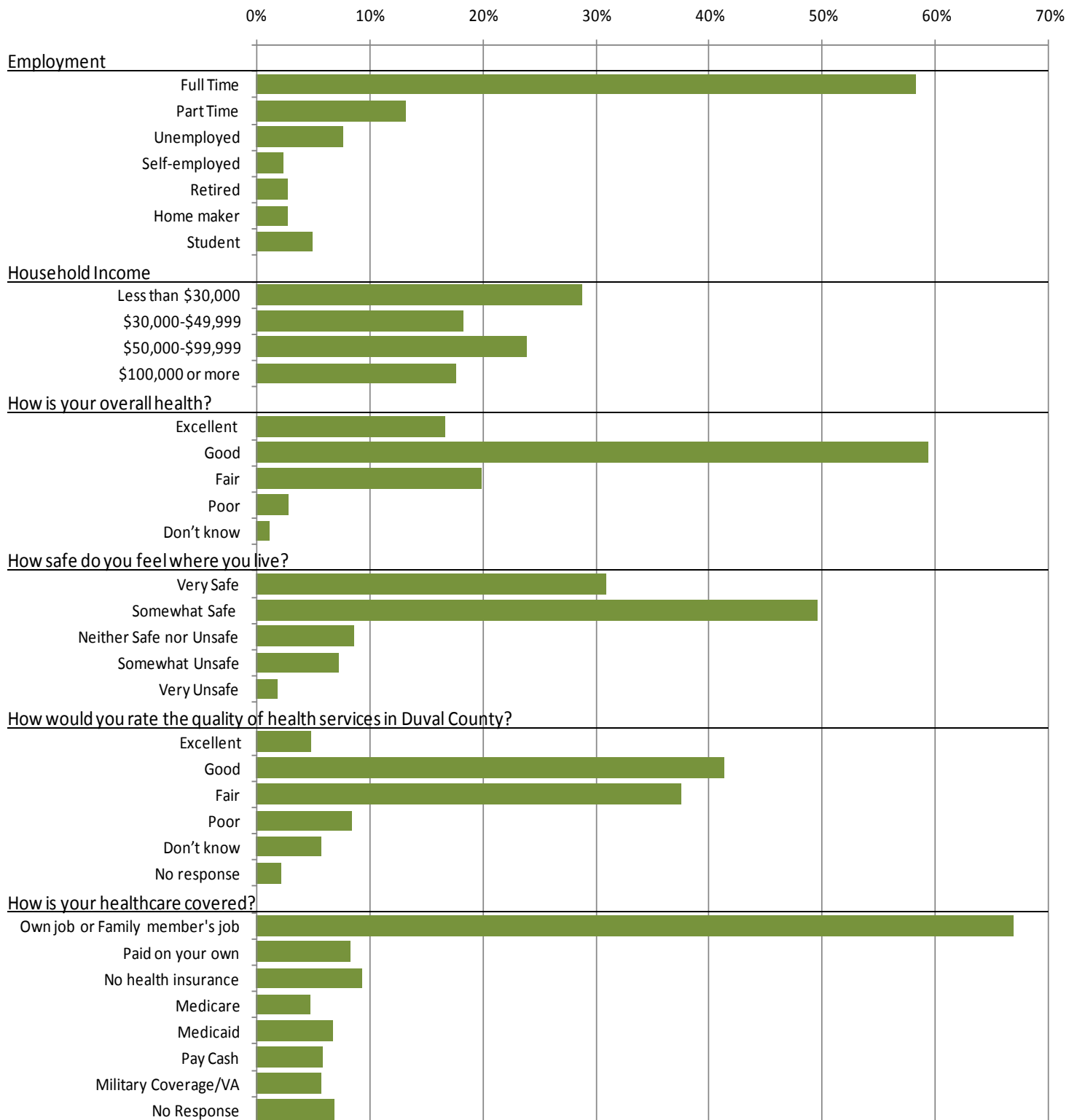


Figure 11: Survey Responses to Multiple Response Questions

(The sum of the percentages for all choices for each question add to more than 100%)

Top 5 things that allow you to be healthy	
Access to healthcare	59.7%
Access to places where I can be active	47.2%
Access to healthy foods	43.6%
Access to churches/places of worship	40.4%
Clean and healthy environment	33.9%

Top 5 health issues you are most concerned about	
Violence	38.9%
Sexually Transmitted Diseases	30.2%
Childhood Obesity	28.0%
Addiction-Drug and Alcohol	26.7%
Adult Obesity	24.3%

Top 5 health behaviors you are most concerned about	
Lack of exercise	42.0%
Being overweight/obese	41.4%
Dropping out of school	39.8%
Drug abuse	39.2%
Teen sexual activity	35.2%

Top 4 places you would go if you were worried about your child's mental, physical, or social health	
Their doctor's office	33.6%
No response	15.3%
Hospital ER in Duval County	9.4%
Local place of worship or community group	7.8%

Top 5 barriers for you getting or staying healthy	
It's hard or expensive to cook/eat healthy	34.4%
I work too much	29.4%
I don't exercise	26.8%
None, I don't have any barriers	21.4%
I don't have good health insurance	15.1%

Top 5 health care services that are difficult to obtain	
None/No Response	42.0%
Alternative Therapy	22.3%
Mental health/counseling	20.2%
Dental/oral care	20.1%
Substance abuse services	14.3%

Top 5 barriers for you in getting healthcare	
None, I don't have any barriers	33.0%
Can't pay for doctors/hospital visits	22.5%
Long waits for appointments	19.7%
Lack of evening and/or weekend service	19.2%
No Response	17.7%

Community Health Status Assessment

The Community Health Status Assessment (CHSA) answered the following questions:

- How healthy are our residents?
- What does the health status of our community look like?

The results of the CHSA informed the community and its leadership about the community's health status and ensured that the community's priorities addressed specific local health status issues. The CHSA examined core indicators for broad-based categories. Health issues were identified and highlighted by gathering data for each category and analyzing differences across time periods, among population subgroups, or with peer, state, or national data.

The CHSA data for Duval County were available from many different state and local government sources. In order to compile the data for this assessment, Healthy Jacksonville staff and public health interns at the University of North Florida gathered available information from data sources available to the public. Data sources included the Florida Community Health Assessment Resource Tool Set (CHARTS), the United States Census, American Community Survey, BRFSS, Jacksonville Community Council Inc. (JCCI), and the Florida Department of Health Office of Vital Statistics.

Data relevant to community health in Duval County and considered remarkable or alarming were selected for the CHSA. Much available information was not included because of the large amount of data available for the many categories of health. MAPP Core Team members reviewed the data and made recommendations for final report design and reproduction. The following categories are presented in the CHSA:

- Demographics
- The Economy
- Employment
- Education
- The Health Delivery System
- Major Diseases
- Health Risk Factors

Figure 12 is a summary of important indicators across several categories collected by JCCI in their Quality of Life Progress Report including the most recent data for each measure as well as how each has changed from the previous year.

Figure 12: Quality of Life Measures for Duval County, 2010

Error! Not a valid link.

Source: Jacksonville Community Council Inc., Community Snapshot, 2012

Demographics

The population of Duval County steadily increased from 2000 to 2010. There appears to be a steady increase in the population since the last census in 2000. As of July 1, 2010, it is estimated that there are 864,263 residents living in Duval County.

Figure 13: Duval County Population, 2000 to 2010

Error! Not a valid link.

Source: Florida Office of Economic and Demographic Research, Revised Intercensal Estimates, May 2011

A majority of Duval County residents fall between the ages of 25 to 64. Only 12.7% of the population of Duval County is aged 65 or older compared to 17.3% of the population of Florida. There are also more males under the age of 25 than females in Duval County, though overall there are more females than males.

Figure 14: Population by Gender and Age for Duval County and Florida, 2010

Error! Not a valid link.

Source: US Census Bureau, 2010

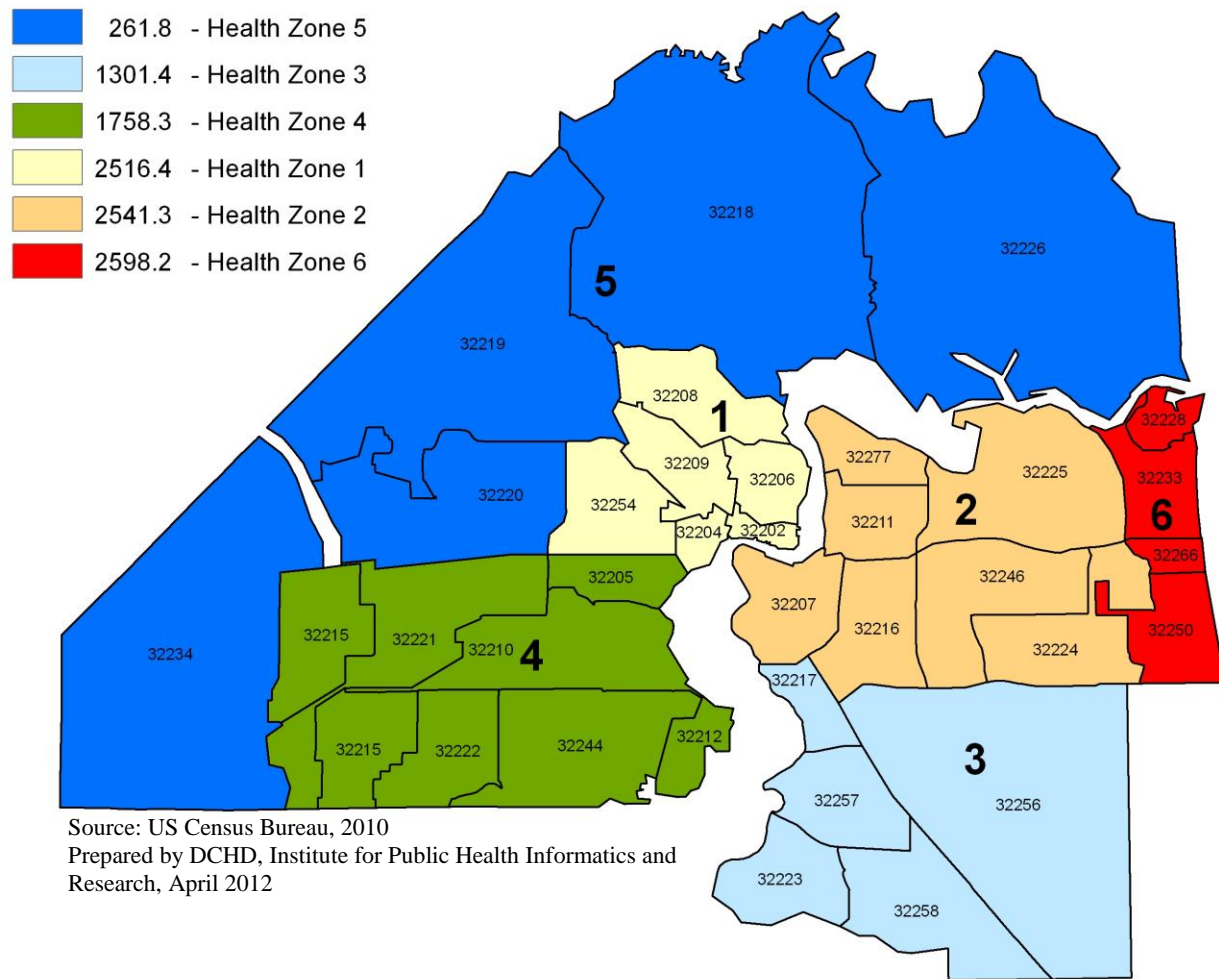
Figure 15 is a graphical comparison showing differences in population by age group for Duval County and Florida.

Figure 15: Population by Age Group for Duval County and Florida, 2010 **Error! Not a valid link.**

Source: US Census Bureau, 2010

The population density has large geographical variations within Duval County. Health Zone 6 has the highest population density, 2598.2 people per square mile, just slightly higher than Health Zones 1 and 2. The population density of Health Zone 5 is much lower than the other health zones at 261.8 people per square mile.

Figure 16: Population Density per Square Mile for Duval County by Health Zone, 2010



Minorities

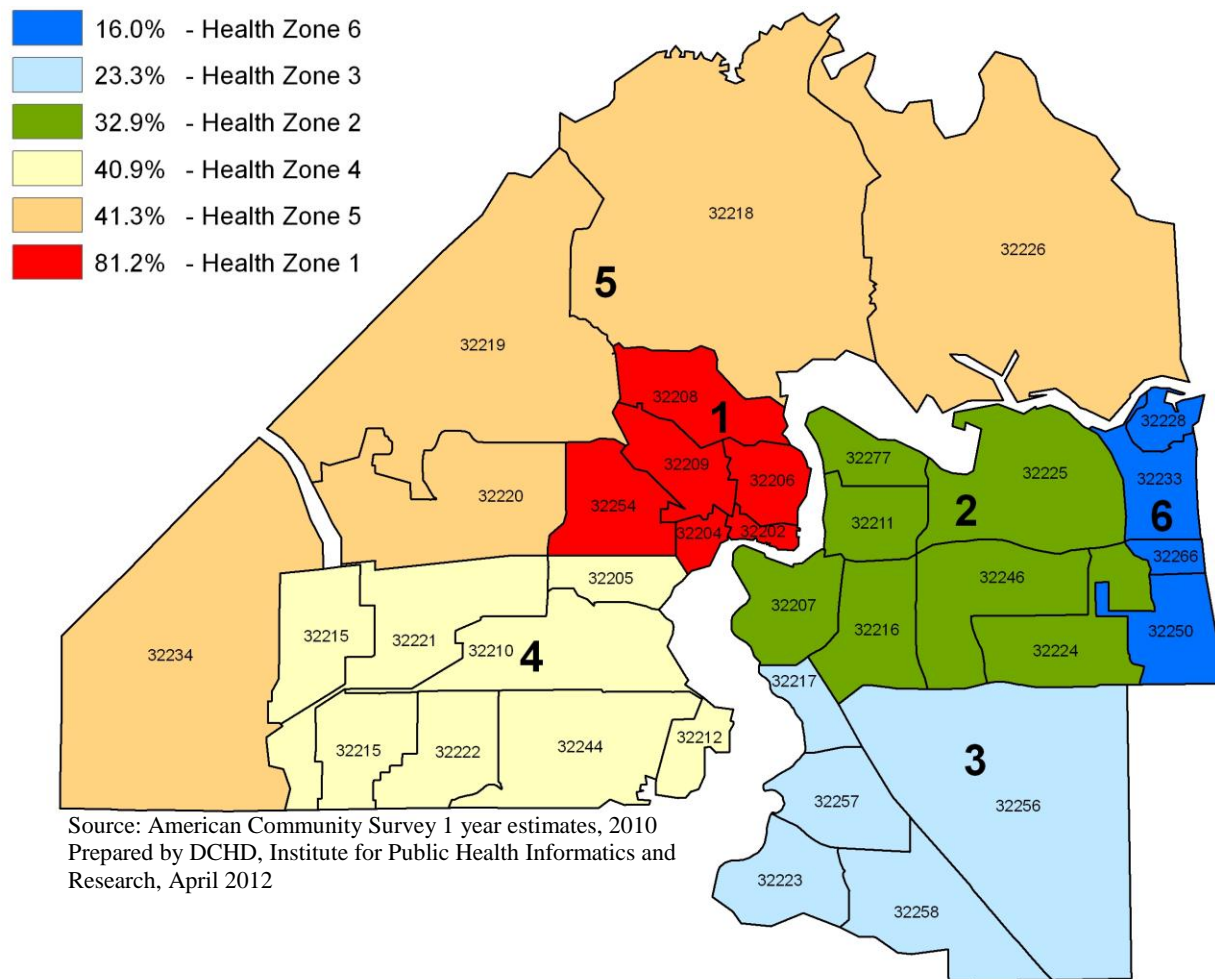
Duval County has a lower percentage of whites and a higher percentage of blacks than Florida. There is also a much lower percentage of Hispanic individuals in Duval County than in the state.

Figure 17: Percent of Population by Race for Duval County and Florida, 2010 Error! Not a valid link.

Source: US Census Bureau, 2010

Health Zone 1 has the highest percentage of residents who are races other than white. The percentage of the minority population in Health Zone 1 is almost twice the percentage of any other health zone.

Figure 18: Minority Population by Health Zone for Duval County, 2010



Economics

Households making more than \$50,000 constitute 46.7% of all households in Duval County, while 27.1% of all households earn less than \$25,000.

Figure 19: Percent of Population by Household Income Bracket for Duval County, 2010

Error! Not a valid link.

Source: American Community Survey 1 year estimates, 2010

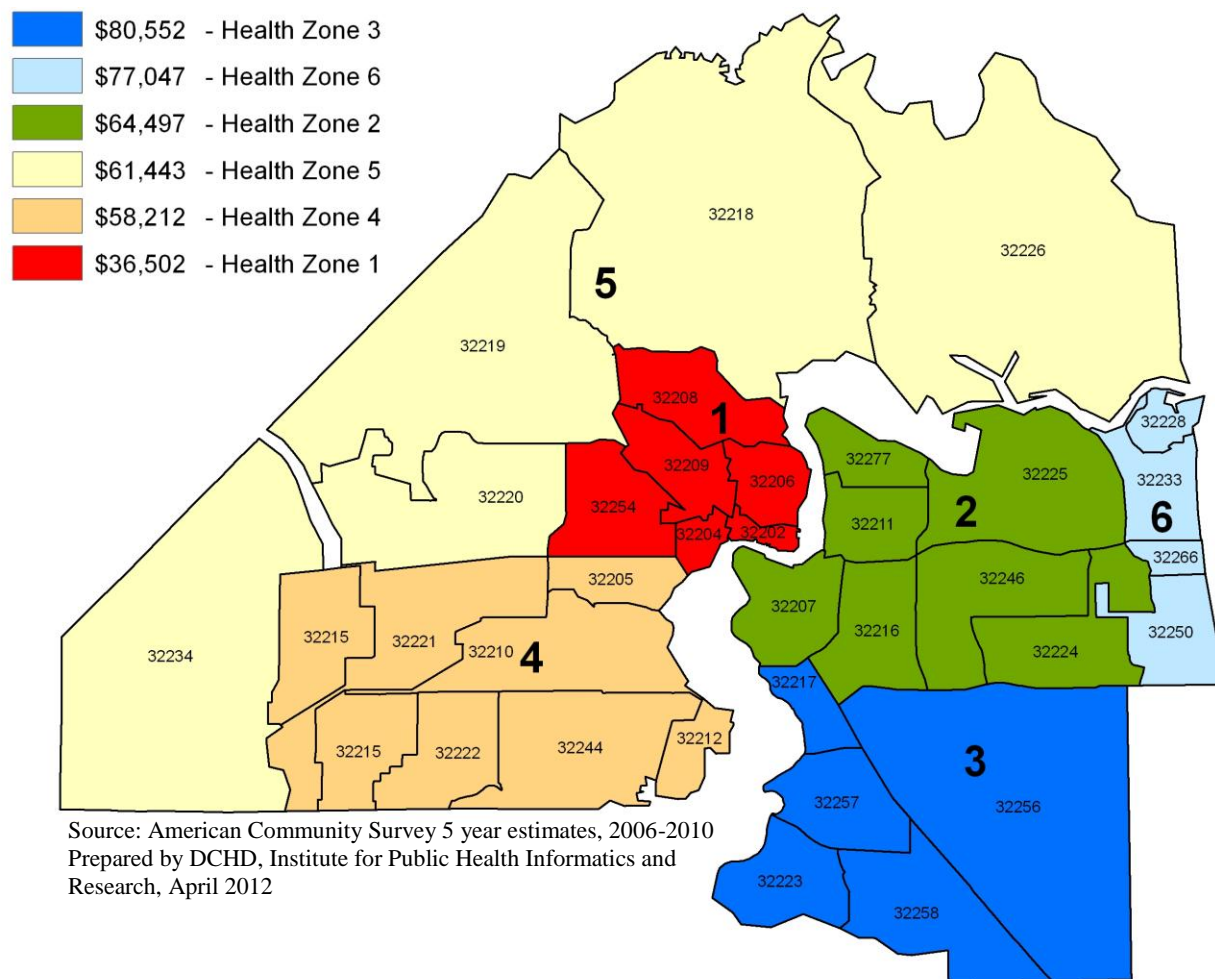
In Duval County, married-couple families have much lower rates of poverty than the average family household. However, female-headed single parent households and non-family households have much higher rates of poverty.

Figure 20: Poverty Status by Household Type for Duval County, 2010 Error! Not a valid link.

Source: US Census Bureau, 2010

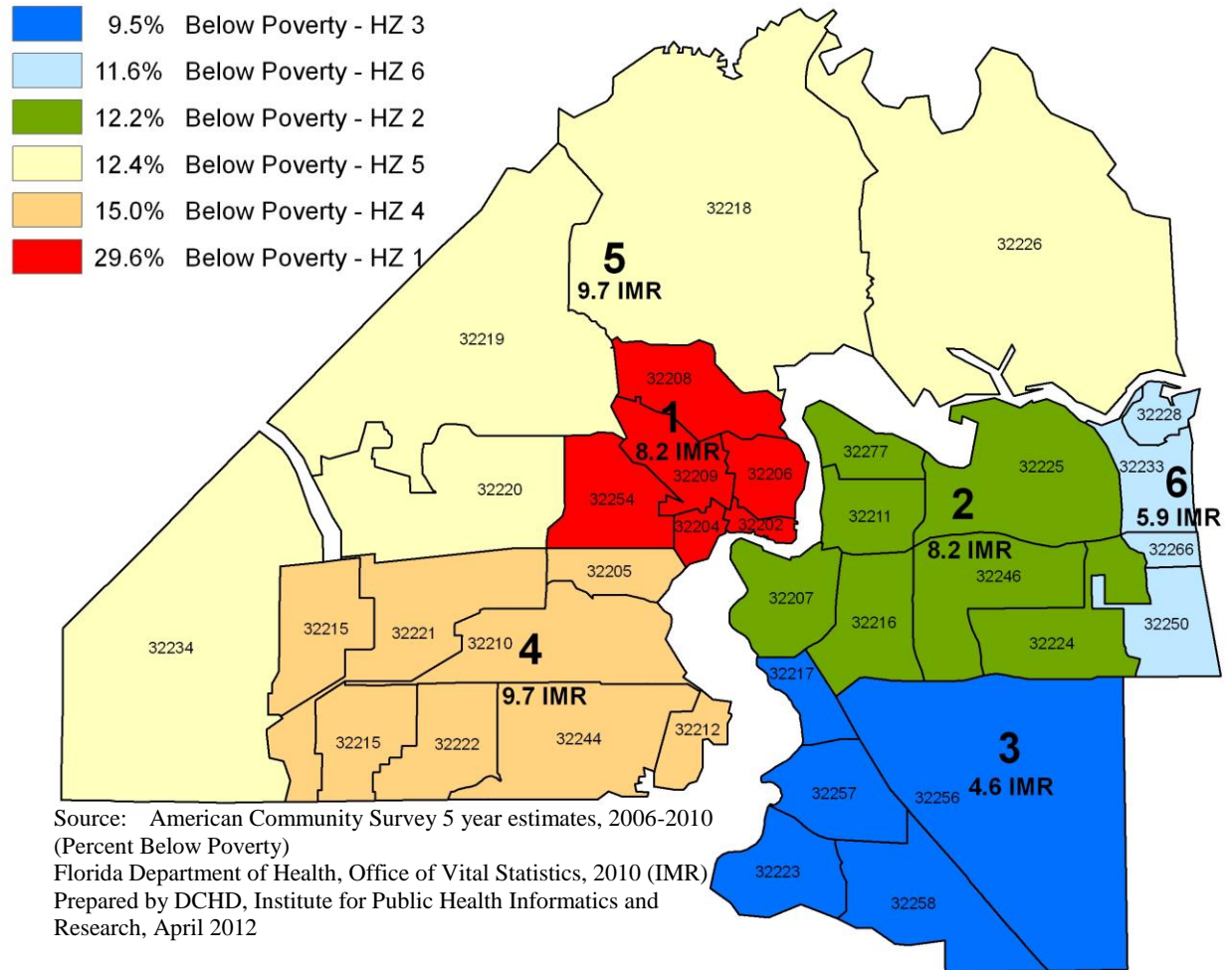
Average household income is lowest in Health Zone 1 while Health Zones 4 and 6 are the highest and are more than double the average of Health Zone 1.

Figure 21: Average Household Income by Health Zone for Duval County, 2010



Health Zones 3 and 6 also have the lowest poverty rates as well as the lowest infant mortality rates (IMR). Health Zones 4 and 5 have the highest IMR.

Figure 22: Poverty and Infant Mortality by Health Zone for Duval County, 2010



Employment

Unemployment is higher for civilian males than females, but a higher percentage of males than females are in the labor force and there are more employed males than females.

Figure 23: Employment Status by Sex for Ages 16 and Older for Duval County, 2010

Error! Not a valid link.

Source: American Community Survey 1 year estimates, 2010

Disability status has a large effect on employment in Duval County. Only 37.1% of residents aged 21 to 64 that have a disability are currently employed, whereas 77.2% of residents that have no disability are employed.

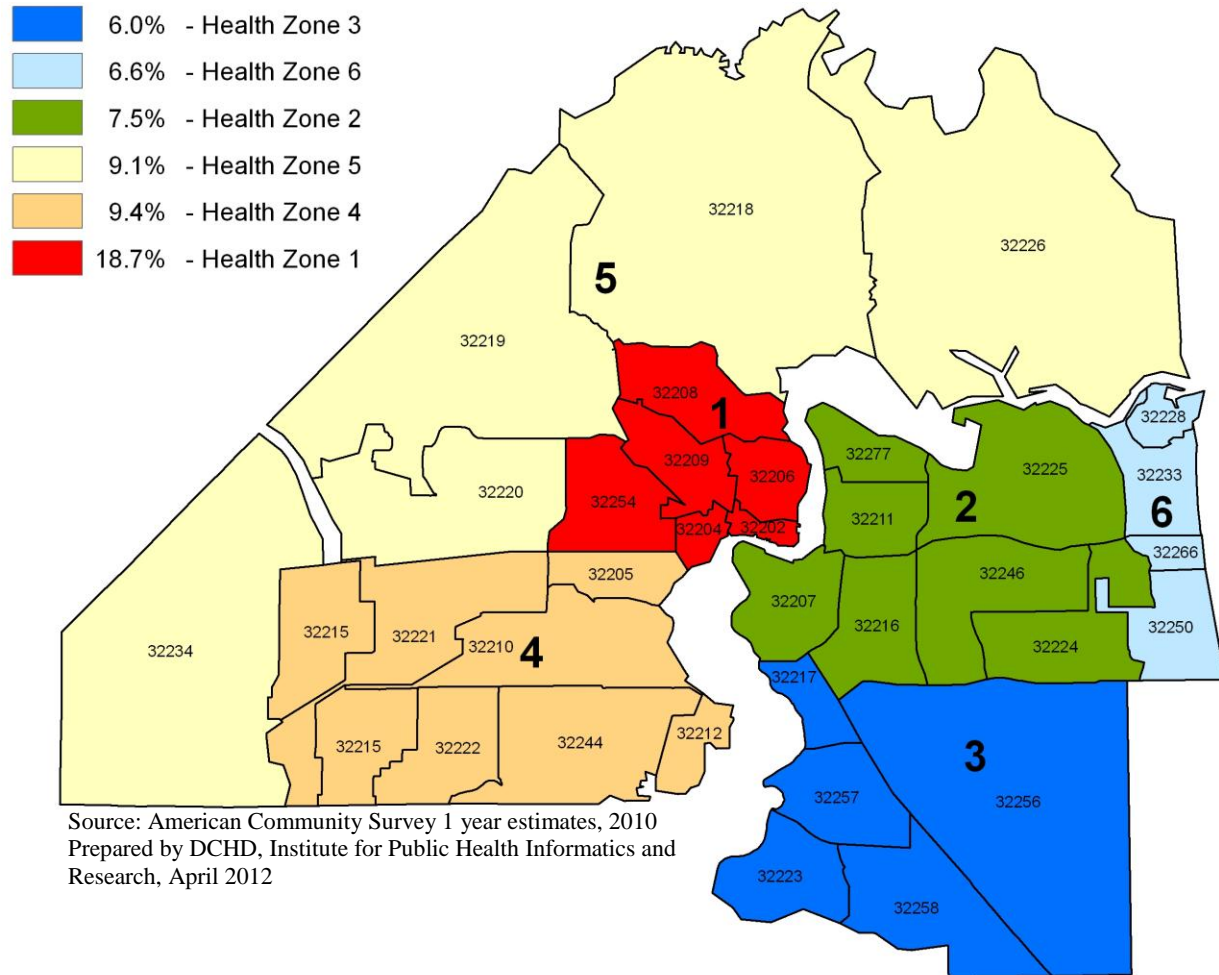
Figure 24: Disability Status of the Civilian, Non-Institutionalized Population by Gender for Duval County, 2010

Error! Not a valid link.

Source: American Community Survey 1 year estimates, 2010

Health Zone 3 has the lowest unemployment rate while Health Zone 1 has by far the highest rate and is almost double the rate of the next highest zone.

Figure 25: Unemployment Rate by Health Zone for Duval County, 2010



Education

For adults aged 18-24, 15.4% are not high school graduates and 51.8% have at least taken some college courses.

Figure 26: Educational Attainment for Ages 18-24 for Duval County, 2010 Error! Not a valid link.

Source: American Community Survey 1 year estimates, 2010

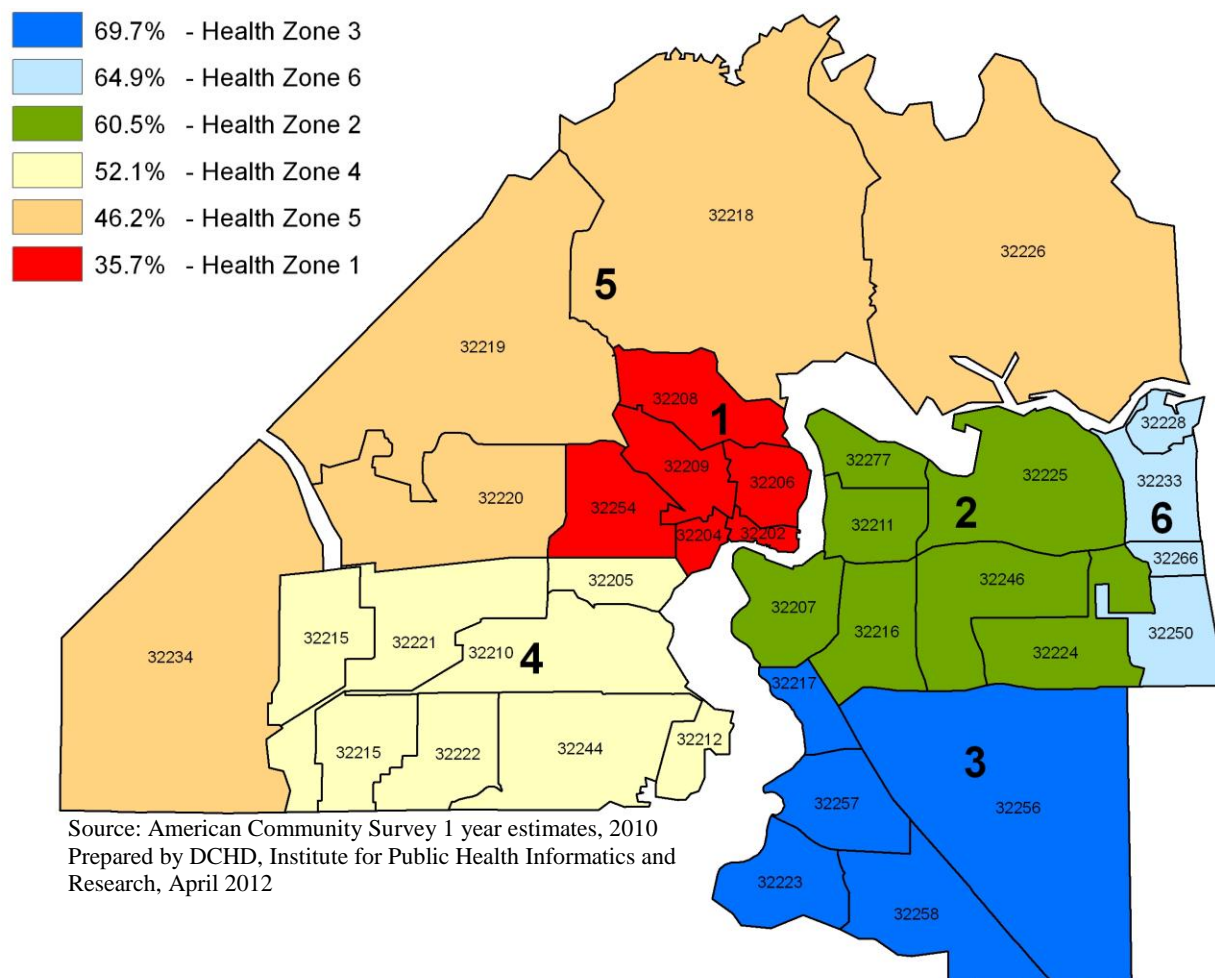
For those aged 25 and older, 12.2% are not high school graduates, but 34.0% have at least an associate's degree and 7.3% hold a graduate or professional degree.

Figure 27: Educational Attainment for Ages 25 Years and Older for Duval County, 2010 Error! Not a valid link.

Source: American Community Survey 1 year estimates, 2010

Health Zone 3 had the highest percentage of the population with more than a high school education (69.7%), while Health Zone 1 has the lowest percentage (35.7%)

Figure 28: Percent of Population with Greater than High School Education by Health Zone for Duval County, 2010



Health System

Duval County has slightly fewer physicians per 100,000 residents than the Florida average. Duval County has more family physicians, OB/GYNs, and pediatricians per 100,000 residents than Florida, but also has significantly fewer dentists.

Figure 29: Physicians per 100,000 Residents for Duval County and Florida, FY2010

Error! Not a valid link. Source: Florida Agency for Health Care Administration, Certificate of Need Office, 2010

Duval County has more acute care and specialty beds per 100,000 residents available than the state average and just slightly fewer nursing home beds per 100,000 residents.

Figure 30: Health Care Facilities per 100,000 Residents for Duval County, 2010

Error! Not a valid link.

Source: Florida Agency for Health Care Administration, Certificate of Need Office, 2010

There are twelve hospitals that serve the emergency needs of greater Jacksonville.

- Baptist
- Baptist – Beaches
- Baptist – South
- Memorial
- St. Luke’s
- St Vincent’s
- Shands
- Orange Park Medical Center
- Flagler Hospital
- Baptist – Nassau
- Ed Fraser
- Mayo Clinic

The number of total emergency department (ED) patients has increased each year from 2007 to 2010 and the rate per 100,000 residents has increased 8.9% during the same time period. The percentage of ED patients being admitted to the hospital has also increased from 19.9% to 21.0% in that time.

Figure 31: Emergency Department Utilization for Duval County, 2007-2010

Error! Not a valid link.
Source: HPCNEF Region 4 Hospital Emergency Department Report, 2010

According to the Florida Association of Community Health Centers, hospitalized patients living in Jacksonville’s urban core went to Shands hospital 48.1% of the time. North Jacksonville residents also visited Shands the most followed by Baptist’s downtown location. While West Duval residents preferred St. Vincent’s, and South Duval residents preferred Memorial.

There are 6 Federally-Qualified Health Centers in Duval County which routinely provide care to uninsured or under-insured adults at a sliding scale based on their income:

- Agape Community Health Center (DCHD)
- West Jacksonville Family Health Center (DCHD)
- South Jacksonville Family Health Center (DCHD)
- South Jacksonville Primary Care Center (DCHD)
- Wesconnett Family Health Center (DCHD)
- IM Sulzbacher Center for the Homeless (Sulzbacher)

DCHD clinics also provide services for mothers and children as well as health professionals working through Volunteers in Medicine Jacksonville and We Care Jacksonville.

Major Diseases

The leading causes of death in Duval County are cancer and heart disease, followed by chronic obstructive pulmonary disease (COPD), accidents, and strokes. These are also the leading causes of death for Florida, but each of these occurs at a higher rate in Duval County. Other leading causes of death include diabetes, kidney disease, influenza and pneumonia, and Alzheimer's.

Figure 32: Leading Causes of Death for Duval County and Florida, 2010 Error! Not a valid link. Source: Florida Department of Health, Office of Vital Statistics, 2010

Accidental deaths by injury are of particular concern because they occur at a higher rate in younger people than other leading causes of death shown above. Injury rates vary by race, with higher rates of total injury deaths and unintentional injury deaths among whites but higher rates of intentional injury deaths among blacks in Duval County.

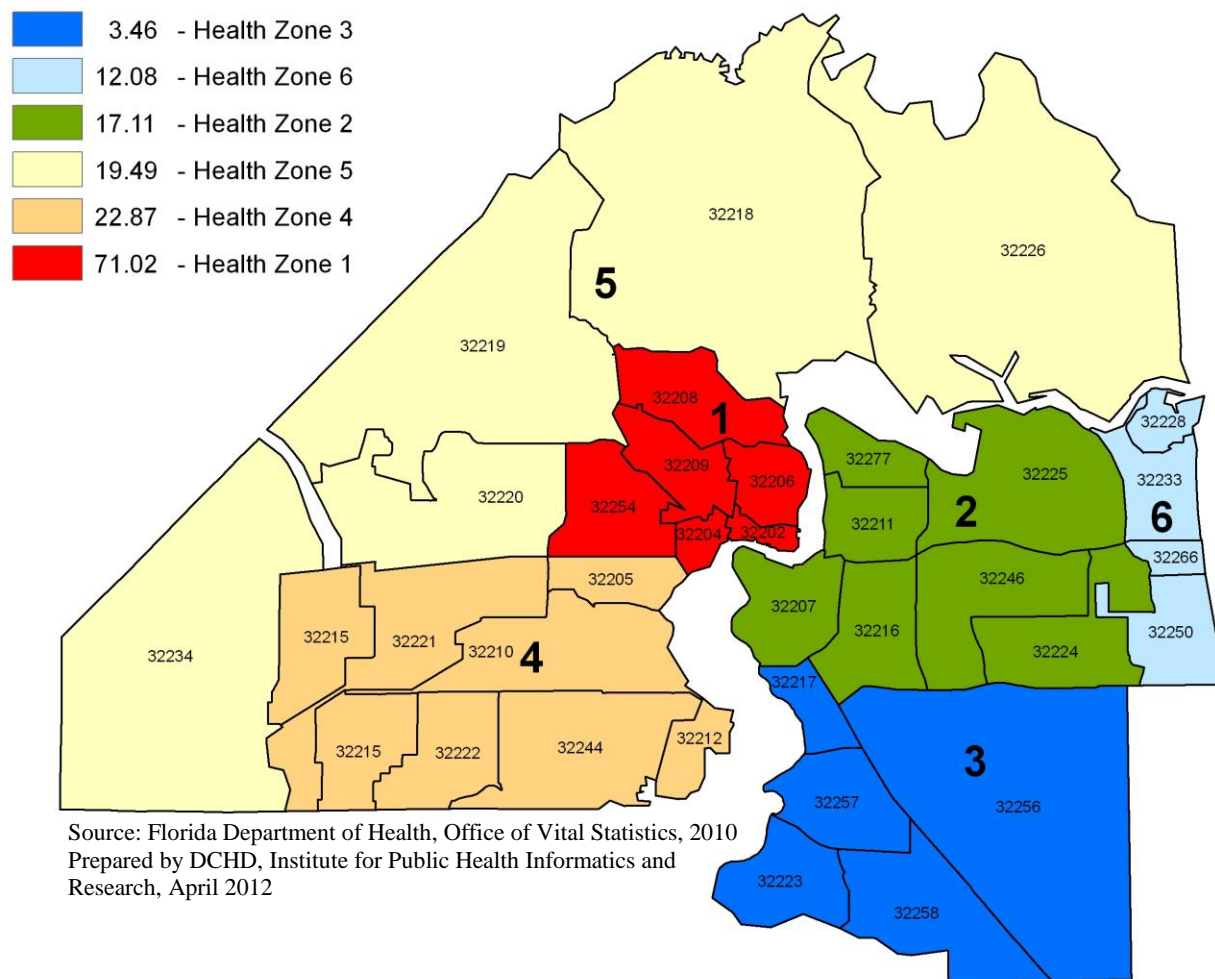
Figure 33: Injury Death Rates by Intent for Duval County, 2010 Error! Not a valid link. Source: Florida Department of Health, Office of Vital Statistics, 2010

Injury deaths also vary noticeably by age, with more intentional injury deaths than unintentional injury deaths for those 15-24. However, intentional injury deaths decrease slightly by age while unintentional injury deaths increase with age.

Figure 34: Injury Death Rates by Age Group and Intent for Duval County, 2010 Error! Not a valid link. Source: Florida Department of Health, Office of Vital Statistics, 2010

Injury deaths also show greater disparity by gender, with males accounting for 68.4% of all injury deaths in Duval County. Deaths due to intentional injury among children and young adults aged 5-34 occur at an alarmingly higher rate in Health Zone 1 (71.02 per 100,000 residents) than in other health zones, with Health Zone 3 being the lowest at 3.46 deaths per 100,000 residents.

Figure 35: Intentional Injury Deaths per 100,000 Residents for Ages 5-34 by Health Zone for Duval County, 2010



Duval County has higher rates of reportable communicable disease than Florida for sexually transmitted diseases, vaccine-preventable diseases, AIDS, and Tuberculosis and ranks in the worst 25% of all Florida counties for all listed diseases except for Acute Hepatitis B.

Figure 36: Reportable Communicable Diseases for Duval County and Florida, 2008-2010

Error! Not a valid link.

Source: Florida Department of Health, Division of Disease Control

Awareness of the widespread nature of mental health disorders is growing. More than a third of hospital admissions in Duval County were related to mental health problems and 13.1% of all emergency room visits were as well. According to BRFSS, 10.3% of all adults in Duval

County reported that they experienced poor mental health on at least half of the last 30 days compared to 11.8% for Florida.

Figure 37: Percentage of Hospital Admissions and Emergency Room Visits for Patients with Mental Health Problems for Duval County and Florida, 2010

Error! Not a valid link. Source: CDC Behavioral Risk Factor Surveillance System, 2010

Risk Factors

There are many health risk factors which contribute to the major causes of death described above. Obesity, poor nutrition, lack of exercise, tobacco use, and excessive alcohol consumption are all important contributing factors to cancer and heart disease as well as several of the other leading diseases. The percentage of the population considered obese and the percentage that is overweight or obese have both increased in recent years for Duval County and Florida. The percent engaging in binge drinking has fluctuated, but smoking rates have steadily decreased.

Figure 38: Percent of Population Considered Obese in Duval County and Florida, 2002-2010

Error! Not a valid link.

Figure 39: Percent of Population who Engage in Binge Drinking in Duval County and Florida, 2002-2010

Error! Not a valid link.

Figure 40: Percent of Population Considered Overweight or Obese in Duval County and Florida, 2002

Error! Not a valid link.

Figure 41: Percent of Population who are Current Smokers in Duval County and Florida, 2002-2010

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Diabetes is an important cause of death in Duval County, and 11.4% of adults in Duval County had diabetes in 2010 compared to 10.4% for Florida. Self-management education, hemoglobin A1c testing, and annual eye and foot exams are important in managing the disease. Duval County rates of self-management education are higher than for Florida, but rates of testing and examination are lower.

Figure 42: Diabetes Risk Factors for Adults in Duval County and Florida, 2010 Error! Not a valid link.

Source: CDC Behavioral Risk Factor Surveillance System, 2010

Receiving vaccinations against preventable diseases is also an important health behavior. Influenza and Pneumonia are largely vaccine-preventable diseases, and while vaccination rates among adults 18-64 are comparable in Duval County and Florida, rates among the high-risk group of adults aged 65 or older are lower for Duval County than for Florida.

Figure 43: Adults Vaccinated Against Influenza and Pneumococcal Disease in Duval County and Florida, 2010 Error! Not a valid link.

Source: CDC Behavioral Risk Factor Surveillance System, 2010

YRBS measures risk factors in middle school and high school youth and was administered in 2009 and 2011 in Duval County. Some notable results from the 2011 survey are shown in Figure 44.

Figure 44: YRBS Results for Middle School and High School Students in Duval County, 2011

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Phase 4: Identify Strategic Issues

Strategic issues are choices or challenges that must be addressed in order to achieve the community's vision. They are not only important but are selected based on the potential opportunity for future growth. During phase 4 of the MAPP process, the findings from the previous phases are reviewed and analyzed to determine where different observations converge to unified themes. These issues are examined for potential benefits, harm caused by inaction, and overlap among issues. This results in a manageable list of priorities.

On January 25, 2011, the Partnership for a Healthier Duval MAPP Core Team engaged in a half-day planning session to begin the process of distilling the findings from the four MAPP Assessments. The team used the Strategic Issue Worksheet and the Relationship Issues Diagram found in Appendix C to determine and arrange a prioritized list based on immediate consequences, timelines, and upcoming events that may affect addressing the issue. The team also considered smaller issues that might be easier to address to build partnership momentum.

The MAPP Core Team discussed related themes and strategic issues based on the 13 areas of concern that emerged from the assessments.

- Violence
- Sexually Transmitted Diseases
- Childhood Obesity
- Mental Health Issues
- Infant Mortality
- Physical Inactivity
- Lack of Dental Care
- Loss of Health Insurance
- Lack of Walkability
- Obesity and Chronic disease
- Deficiencies in informing, educating and empowering people about personal health
- Failure to evaluate effectiveness
- Lack of mechanisms and systems to link people to needed health services

The Core Team synthesized these 13 areas of concern into four broad-based strategic issues facing Duval County that impede our ability to realize our vision:

- **Access to Health Care**
- **Mental and Behavioral Health**
- **Chronic Care Management**
- **Communication**

Phase 5: Formulating Goals and Strategies

During the fifth phase of the MAPP process, the MAPP Core Team identifies a few major goals related to the strategic issues from phase 4. They also develop specific strategies which create a road map for reaching those goals.

The MAPP Core Team engaged the community to formulate goals and strategies for addressing the 4 priority areas. Since the Duval County MAPP Team is part of NACCHO as well as a member of the Florida DOH MAPP Team, they also reached out to other cities and counties that have been part the planning process. After consulting with Lux Phatak, the assessment coordinator for Delaware County, Ohio, the team customized tools from the Partnership for a Healthier Delaware to formulate goals and strategies at a meeting held at WJCT on February 10, 2011. The overall vision, assessment results, and goals identified by the MAPP Core Team are shown below.

Figure 45: Duval County Vision, Assessment Results, and Health Priorities



The goal setting exercise for Access to Healthcare is included in Appendix B. All the other priority areas went through the same process in this phase.

Phase 6: Action Cycle

The final phase of the MAPP process links planning, implementation, and evaluation in a continuous cycle of action. Based on clear goals and strategies from phase 5, objectives are developed, action plans implemented, and evaluations performed to improve the health of the community.

Planning involves taking the inputs from the previous phase and defining specific, measurable objectives, assigning responsibility for those objectives to particular organizations, and developing timetables for reaching those objectives. Properly establishing accountability for responsible parties is also important. Finalized action plans for each goal include specific objectives, targets, implementers, timeframes, and resources needed for completion.

Implementation finally takes the results of the MAPP process and puts them into action. All MAPP participants should be involved in implementing at least one strategy and participants should constantly consider whether other partners should be included to achieve better implementation.

Evaluation should be considered from the beginning of the action cycle so that implementation is done in a way that is measurable in a reasonable amount of time and without excessive cost. Evaluation of both the entire MAPP process and each strategy is necessary. Evaluations should be useful to the community, accurate, and should conform to accepted legal and ethical standards. Lessons learned from the evaluation should lead to implementation refinements and the celebration of successes.

Community Health Improvement Plan

Community Health Priority #1 – Increase Access to Health Services

Why this is important to our community:					
One of the chief barriers to improving community-wide health outcomes is the inability to access available resources. Causes of inaccessibility include, but are not limited to addressing poverty, unaffordable health insurance, and low health literacy. These social determinants of health disproportionately affect Duval's low socio-economic status groups. Strategies will be implemented to educate families and individuals so they will be able to make informed health decisions that will ultimately improve their well being. In addition, the support of our community organizations in addressing various barriers will greatly increase access to care.					
Strategic Objective	Measure	Current Performance Level	Target	Critical Actions	Status (Red, Yellow, Green)
1.1 Increase the proportion of Duval County residents who use electronic personal health management tools by 10% by December 31, 2013	Percent of residents who use the internet to keep track of personal health information	TBD	TBD	Develop electronic personal health management tools for education and care coordination Improve awareness of existing personal health management tools	
1.2 Increase the proportion of Duval County residents with health insurance to 90% by December 31, 2015	Percent of persons with health insurance (BRFSS)	77.3% insured	90% insured	Simplify application process for KidCare, Medicaid and other indigent care programs	
1.3 Increase the number of primary care providers in the health care safety net in Duval County by 10% by December 31, 2015	Number of PCPs in Duval County	1,047 (FY2010)	TBD	Ensure HRSA New Access Point grants are applied for locally	

Strategic Objective	Measure	Current Performance Level	Target	Critical Actions	Status (Red, Yellow, Green)
1.4 Increase the number of Partnership for a Healthier Duval member organizations that include a social determinant of health objective in their strategic plan by 25% by December 31, 2013	Number of organizations with a social determinant of health objective	TBD	TBD	Survey development and dissemination to community partners to assess baseline Agreement by partners to incorporate social determinant of health into strategic plan	
Key Community Resources					
<p>Duval County Health Department Federally Qualified Health Centers - WIC Clinic http://www.dchd.net/wicsites.htm</p> <p>We Care Jacksonville http://www.wecarejacksonville.org/</p> <p>NE Florida Community Dashboard - A one-stop source of population data and information about community clinical recommendations come from the US Preventive Services Task Force (USPSTF) http://www.uspreventiveservicestaskforce.org/tools.htm</p> <p>Duval County Public Schools http://www.duvalschools.org/</p> <p>National Prevention Strategy http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf</p> <p>Healthy People 2020 - Objectives, targets and measures as well as evidence-based community and clinical interventions http://www.healthypeople.gov/</p>					

Status Key:

- Red denotes Little on no movement - more work to be done
- Yellow denotes some progress towards meeting our identified goal
- Green denotes reached or surpassed our community health goal

Community Health Priority #2 – Increase Access to Mental Health Services

Why this is important to our community:					
<p>In 2009, 10.4% of hospital visits in Duval County were mental health related. Mental health disorders are the largest cause of disability. They are closely linked with physical health and the ability to participate in work, school, and interpersonal relationships, and contribute to society. Recently, the importance of mental health disorders has been more fully realized, so preventive care and case management are in the early stages of development. Given these challenges, it is important to integrate services and develop an efficient and seamless system of care that is accessible to the entire population of Duval County.</p>					
Strategic Objective	Measure	Current Performance Level	Target	Critical Actions	Status (Red, Yellow, Green)
2.1 Increase the proportion of primary care facilities that provide mental health treatment by 10% by December 31, 2015	Number of facilities that provide treatment	TBD	TBD	<p>Increase number of mental health providers across all specialties</p> <p>Increase points of entry into the system of mental health care</p>	
2.2 Decrease the number of poor mental health days experienced by adults by 10% by December 31, 2015	Average number of unhealthy mental days in the past 30 days (BRFSS)	3.6 days	3.3 days	<p>Increase awareness about availability of mental health resources</p> <p>Public education campaign to increase understanding of mental health</p>	
Key Community Resources					
<p>Wolfson Children's Hospital - Provides a comprehensive continuum of mental health services to children and adolescents http://www.wolfsonchildrens.org/</p> <p>Safe & Healthy Duval Coalition http://www.shdcfl.org/</p> <p>Suicide prevention http://www.floridasuicideprevention.org/</p>					

Key Community Resources (continued)

Partnership for Child Health - A coalition of pediatricians and child health organizations committed to improving the health and well-being of children in NE FL

<http://partnershipforchildhealth.org/>

Kids 'N Care - A SAMHSA grant managed under the Partnership for Child Health to provide sustainable, family centered and evidence-based physical and mental health services to children

<http://www.dchd.net/kidsncare.htm>

River Region Human Services - Mental health case management, supported housing, and rehabilitative services for adults with severe and persistent mental illness

<http://www.rrhs.org/>

Mental Health Resource Center - Provide comprehensive mental health services for adults

<http://www.coj.net/departments/recreation-and-community-services/behavioral-and-human-services/mental-health-services.aspx>

Status Key:

- Red denotes Little on no movement - more work to be done
- Yellow denotes some progress towards meeting our identified goal
- Green denotes reached or surpassed our community health goal

Community Health Priority #3 – Improve Chronic Care Management

Why this is important to our community:					
Almost 50% of Americans live with a chronic condition that requires them to interact with the healthcare system. Once a patient has a chronic condition, they can be managed by a primary care physician. Care management is important so that services are not duplicated and correct treatments provided. Fortunately, treatment protocol adherence usually produces an improved disease state as well as increased quality of life.					
Strategic Objective	Measure	Current Performance Level	Target	Critical Actions	Status (Red, Yellow, Green)
3.1 Decrease percentage of emergency room visits due to ambulatory care sensitive conditions by 10% by December 31, 2015	Percent of ER visits due to ACSCs	TBD	TBD	Provide accessible, affordable, timely transportation for healthcare services Provide mobile health services to the community	
3.2 Establish coordinated system for chronic care management and expansion clearinghouse by December 31, 2015	Formal MOA development	TBD	TBD	Seek and apply for grants related to chronic care management Include evidence-based methodologies in new grant applications and treatment protocols Create a clearinghouse to streamline and coordinate grant applications for chronic care management Develop and enhance relationships with public/private corporate sponsors	
3.3 Increase the proportion of persons with a usual primary care provider to 90% by December 31, 2017	Percent of population with a PCP (BRFSS)	85.7% (2010)	90%	Develop referral service for health care system users without a PCP	

Key Community Resources

Duval County Health Department – Nutrition and Chronic Disease Prevention

<http://www.dchd.net/community%20nutrition.htm>

HERAP – Hospital Emergency Room Alternative Program

<http://www.dchd.net/herap.htm>

First Coast YMCA’s Diabetes and Brooks Stroke Wellness Programs

http://www.firstcoastymca.org/wellness/diabetes_prevention

http://www.firstcoastymca.org/programs/stroke_wellness

Baptist Health System

<http://www.e-baptisthealth.com/>

St. Vincent Healthcare

<http://www.jaxhealth.com/>

Northeast FL Medical Society

<http://www.nefms.org/>

Healthy People 2020

Objectives, targets and measures as well as evidence-based community and clinical interventions

<http://www.healthypeople.gov/>

Status Key:

- Red denotes Little on no movement - more work to be done
- Yellow denotes some progress towards meeting our identified goal
- Green denotes reached or surpassed our community health goal

Community Health Priority #4 – Enhance Communication within the Local Public Health System

Why this is important to our community:					
Linking Duval County residents to available and appropriate resources within the community requires coordination across health service providers as well as other sectors. Optimal continuity of care must be ensured when the point of entry for a patient is no longer the best location to receive health services. Because so many aspects of a person's life are influenced by their health, it is important to consider many different sectors when analyzing the local public health system. Additionally, tracking objectives and communicating successes and needs related to the CHIP are vital to ensure that goals are achieved.					
Strategic Objective	Measure	Current Performance Level	Target	Critical Actions	Status (Red, Yellow, Green)
4.1 Create and communicate a formalized health system process to ensure continuity of care for Duval County residents by December 31, 2015	Formal MOA Development Proportion of residents who know how to use available resources	TBD	TBD	MOA development with key health system partners Conduct community meetings through focus groups, surveys and dialogue to ensure that the system meets the needs of the community and will be easy for them to use Enhance online community information sites and electronic health tools Promote the use of NE FL Counts for sharing information regarding activities and opportunities	
4.2 Create a dashboard to track progress towards meeting CHIP objectives by December 31, 2013	Percentage of CHIP objectives tracked	0%	100%	Create dashboard where all partners can view progress towards objectives Establish baselines for all objectives Develop process of regularly updating objective status from appropriate partners	

Strategic Objective	Measure	Current Performance Level	Target	Critical Actions	Status (Red, Yellow, Green)
4.3 Increase the number of member organizations in the Partnership for a Healthier Duval from outside the health sector by 10% by December 31, 2013	Number of organizations in partnership	TBD	TBD	Encourage partners from inside the health sector to reach out to other organizations	

Key Community Resources

**Duval County Health Department –
Public Health Communication and Planning, Institute for Public Health Informatics and Research**
http://www.dchd.net/services/hper/new/hper_home2.htm

Jacksonville Community Council, Inc.
<http://www.jcci.org/>

City of Jacksonville
<http://www.coj.net/>

Health Planning Council of NE FL
<http://www.hpcnef.org/>

Healthy People 2020
 Objectives, targets and measures as well as evidence-based community and clinical interventions
<http://www.healthypeople.gov/>

Status Key:

- Red denotes Little on no movement - more work to be done
- Yellow denotes some progress towards meeting our identified goal
- Green denotes reached or surpassed our community health goal

Community Health Improvement Plan – Action Steps

Community Health Priority #1:

Increase Access to Health Services

Strategic Objective 1.1:

Increase the proportion of Duval County residents who use electronic personal health management tools by 10% by December 31, 2013

Critical Action 1.1.1:

Develop electronic personal Health Management tools for education and care

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when? Month/day/yr</i>
1. Identify what best practices are being used in Duval County	1. Baptist, UNF, FSCJ, and Nemours	1. Apps for your phone & Pedometer program for all Duval Country Residents, Public Service announcements, radio, or TV	1.
2. Identify the various types of electronic media that people have. E.g. – Smart phones and cell phones	2. Baptist, UNF, and FSCJ	2.	2.
3. Develop a communication tool to communicate awareness	3. Duval County School Board	3. The school system has a program called Health Teachers which can be used to communicate health information to parents and students	3.
4. Increase awareness of clinical and research resources from Nemours	4. Nemours PR	4. Jim Sylvester (Facilitator), In-kind unless actual research project initiated	4. Ongoing

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Who is missing? *(What other agencies or organizations need to be included?)*

School superintendent/School system to promote awareness

Community Health Priority #1:**Increase Access to Health Services****Strategic Objective 1.1:**

Increase the proportion of Duval County residents who use electronic personal health management tools by 10% by December 31, 2013

Critical Action 1.1.2:

Improve awareness of existing personal health management tools coordination

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Maintain information on the library system for citizen to access	1. Duval Library and The Extension Center	1. Library Communication System	1.

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Who is missing? *(What other agencies or organizations need to be included?)*

Community Health Priority #1:**Increase Access to Health Services****Strategic Objective 1.2:**

Increase the proportion of Duval County Residents with health insurance to 90% by December 31, 2013

Critical Action 1.2.1:

Simplify the application process for all residents

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when? Month/day/yr</i>
1. Train the Trainer - all organizations that are a part of this partnership will have a representative to come to a central location to receive a trained on how to fill out/complete the application process and then take that information back to their organization and train their staff on the application process	1. Carol Brady and Saint Vincent's Hospital together will create the training; Baptist Hospital committed to doing community base trainings when they are out in the community on how-to complete the application process	1.	1.
2. Research United Way and Palm Beach County's one stop shop process	2. Steve Rankings of JCCI	2. United Way and Palm Beach County's one stop shop process	2.

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Who is missing? *(What other agencies or organizations need to be included?)*

Community Health Priority #1:**Increase Access to Health Services****Strategic Objective 1.3:**

Increase the number of primary care providers in the health care safety net in Duval County by 10% by December 31, 2013

Critical Action 1.3.1:

Increase the number of PCP's in the Health Care safety net

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Perusing more academic health funding	1. DCHD – AD Timothy Lawther	1. Academic Health Funding	1.

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Who is missing? *(What other agencies or organizations need to be included?)*

Community Health Priority #1:**Increase Access to Health Services****Strategic Objective 1.4:**

Increase the number of Partnership for Healthier Duval member organizations that include a social determinant of health objective in their strategic plan by 25% by December 31, 2013

Critical Action 1.4.1:

Survey development and dissemination to community partners to assess baseline

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Defining social determinant and educating our partners about its meaning	1. Carol Brady, Jeff Goldhagen, and IPHIR	1. Staff time	1.
2. Conduct survey to ascertain who has and does not have a social determinant in their strategic plan	2. DCHD Research Department (IPHIR)	2. Staff time	2.

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Who is missing? *(What other agencies or organizations need to be included?)*

Community Health Priority #1:**Increase Access to Health Services****Strategic Objective 1.4:**

Increase the number of Partnership for Healthier Duval member organizations that include a social determinant of health objective in their strategic plan by 25% by December 31, 2013

Critical Action 1.4.2:

Agreement by partners to incorporate social determinant of health into strategic plan

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when? Month/day/yr</i>
1. The partnership spearheaded by a subgroup to develop the agreement that the partners have agreed that they have the social determinant in their strategic plan	1. Annie Rodriguez	1.	1.

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Who is missing? *(What other agencies or organizations need to be included?)*

Community Health Priority #2:
Increase Access to Mental Health Services

Strategic Objective 2.1:

Increase the proportion of primary care facilities that provide mental health treatment by 10% by December 31, 2015

Critical Action 2.1.1:

Increase the number of mental health providers across all specialties

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Increase volunteers (individuals) psychiatrists, LMHCC, Social workers in We Care Jacksonville	1. Sue Nussbaum, We Care Jacksonville	1. Access to current providers	1. August 31, 2012
2. Establish a process for mental health providers to join a Disaster Mental Health Team	2. Theresa Isaac, DCHD	2. Mental Health Outreach coordinator	2. June 30, 2015
3. Encourage Mental Health Organizations/providers to sign MOUs to provide Disaster Mental Health Services	3. Theresa Isaac, DCHD	3. Marketing recruitment material	3. June 30, 2015

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

A roster of mental health service teams.
Written community disaster mental health plan

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

TBD by December 31, 2013

Who is missing? *(What other agencies or organizations need to be included?)*

Mental Health Coalition

Community Health Priority #2:
Increase Access to Mental Health Services

Strategic Objective 2.2:

Decrease the number of poor mental health days experienced by adults by 10% by December 31, 2015

Critical Action 2.2.1:

Public Education campaign to increase understanding of mental health

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Provide education on mental health and chronic disease management in the DCHD Diabetes Self-Management Program (New DEAL)	1. A New DEAL Program	1. In Diabetes Self-Management Education class every other month	1. Bi-monthly
2. Educate dietetic and community health interns on mental health and diabetes simultaneously	2. A New DEAL Diabetes Program	2. Internship rotations with UNF, UF, Pasco, and Mayo	2. TBD by December 31, 2013
3. Screen A New DEAL's clients for depression	3. A New DEAL Diabetes Program	3. A New DEAL	3. TBD by December 31, 2013
4. Recruit (partner with mental health programs to provide education to A New DEAL Program participants).	4. A New DEAL Diabetes Program	4. A New DEAL Diabetes Program and DCHD- already in discussion	4. TBD by December 31, 2013
5. Promote mental health during workshops	5. Jodie Thomas	5. Prevention Department	5. Immediately
6. Create, approve and utilize a survey tool to measure each workshops effectiveness	6. Zendra Hansley & Jodie Thomas	6. Prevention Department	6. Within 3 weeks
7. Provide public education campaign to increase understanding of mental health	7. UNF MS/DT: Program Director supervising and directing graduate students to disseminate information	7. UNF Dietetics in partnership with Healthy Jacksonville at DCHD	7. December 31, 2013
8. Increase awareness about availability of mental health resources	8. Dietetic interns at specific times in the program under leadership of Director Dr. Sealey-Potts	8. UNF Dietetics in partnership with Healthy Jacksonville at DCHD and Mental Health Coalition	8. December 31, 2013
9. Develop campaign geared toward increasing knowledge and identifying individuals in need of mental health.	9. Dietetic interns at specific times in the program under leadership of Director Dr. Sealey-Potts	9. UNF Dietetics in partnership with Healthy Jacksonville at DCHD and River Region	9. December 31, 2013

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
10. Incorporate screening into WIC certification process	10. WIC Certification staff.	10. Electronic records to maintain continuity of care	10. December 31, 2012
11. Implement an active referral system and cooperative agreements to maintain continuity of care for clients	11. WIC staff and community partners	11. Mental health professionals	11. TBD by December 31, 2013
12. Provide parents/guardians with information on mental health resources	12. Family support specialist at Episcopal Children's Services' Centers	12. Make resources available for Medicaid and private pay clients	12. Fall 2012
13. Share information on recognizing mental health concerns with adult clients	13. Family support specialist at Episcopal Children's Services' Centers	13. Professional experts to present informational materials for distribution	13. Winter 2013
14. Provide mental health education of health professionals not in the field.	14. Mental health experts will educate nutritionists in WIC, RDs, NEs, & staff performing assessments	14. Grants, this should be a part of normal process	14. Dec, 15, 2015
15. Learn how to integrate screening into the WIC process, make and suggest mental health referrals, select enough of the appropriate staff to handle the task	15. RDs, camp counselors, NEs, ministers, school counselors, sports coaches, and retreat counselors	15. Barter, partnerships, collaborative grants and health insurance	15. Education by December 2013; Follow up by December 2014; Findings by December 2015
16. Do community outreach on mental health services done by River Region Health Services (RRHS)	16. Yvette Malone (904) 899-6300 ext 4451	16. Give out materials and flyers	16. Ongoing
17. Twice a year at functions, we'll set up awareness booths and materials to emphasize mental health services provided by RRHS.	17. Robin Spires (904) 899-6300 ext 4202	17. Facilitate outreach and public service relations via mental health counseling staff and pamphlets	17. September 30, 2012
18. Share with children's treatment program the need for co-occurring disorder services	18. Tang Heard (904) 463-1967	18. Department of Children and Families/TBD	18. December 31, 2013
19. Provide community education workshops on mental health at local clinics, faith centers, schools, and workplaces	19. Community leaders, HR, health centers and school boards	19. Public and private funding	19. Quarterly
20. Use the media to disseminate information	20. Health Educators, nutritionists and law enforcement agencies	20. Public and private funding	20. Quarterly
21. Become a member of the Mental Health Coalition	21. LaRonda Howard-AmeriCorp member	21. Meeting time	21. Depends on meeting time

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
22. Learn more about current mental health services available	22. LaRonda Howard – Americorp member	22. DCHD, River Region, Mental Health Coalition, credible internet sources	22. TBD by December 31, 2013
23. Incorporate mental health resources into community programs and outreach	23. Community agencies who come in contact with adults	23. Create marketing material with mental health resources (various agencies)	23. Depends on agency, availability of funding and budget appropriation

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

#8: Provide/ implement at least one health needs assessment, use a pre/post assessment technique. Summarize the # of individuals identified after each fair. (Benchmark: 1 education/assessment program per year)
 #10-12: Hospital visits due to mental health issues decrease
 #13-14: Parents will know where to go if they have a mental health concern
 #15: Individual success: How concerns shrink, the persistence of the un-wellness should be measured. Other measures include: emotions, actions toward other people and themselves, work accomplishments, attitudes, etc.
 #16: Benchmarks: based on what we've seen, education in various topics, # of people educated, reduction in hospital visits, reduction in mental health medications
 #17-19: The # of materials distributed; increases in attendance, program data and the DCF Report Card
 #20-21: When there is a noticeable decrease in 1) the # of recorded mental health cases, 2) the # of incidents of substance abuse and 3) crime rates
 #22. Being a member of the Mental Health Coalition
 #23. More knowledgeable of mental health
 #24. Brochures, flyers, and handouts on mental health are available

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

#8: Pre/post assessment – measures = knowledge, # of participants, # of referrals per session
 #13-14: Survey-brief, self report at the beginning and end of year
 #15: Ask the individual how they feel.
 #16: The # of clients and specialty professionals educated
 #17-19: The DCF Report Card
 #20-21: There is noticeable behavior changes: Lifestyle change to healthier lifestyles that include abstaining from substance abuse
 #22. Staff meetings/ Agency meetings
 #24. Increase in the # of participant referrals to mental health providers and a decrease in the # of poor mental health days experienced by adults

Who is missing? *(What other agencies or organizations need to be included?)*

Underserved groups, homeless shelter, Volunteers In Medicine (VIM), NEFL AHEC, Jacksonville Journey, Early Learning Coalition, (children's services in general), Solantic, private institutions and physician offices, sports leaders, churches, ER nurses/staff, public health staff- all levels, Department of Children and Families (DCF), law enforcement agencies, faith centers, psychologists, hospitals, social work facilities, Mental Health Coalition, schools, non-profits and other community agencies.

Community Health Priority #3:
Improve Chronic Care Management

Strategic Objective 3.1:

Decrease percentage of emergency room visits due to ambulatory care sensitive conditions by 10% by December 31, 2015

Critical Action 3.1.1:

Provide accessible, affordable, timely transportation for healthcare services

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Identify current services available	1. DCHD	1. staff time	1. September 30, 2012
2. Convene first Healthcare Transportation group	2. DCHD and United Way	2. staff time	2. June 30, 2013
3. Develop a healthcare transportation plan funded by an increase in sales tax	3. Healthcare Transportation Group	3. staff time	3. December 31, 2013
4. Get buy-in from stakeholders to support and pass sales tax	4. City Council/ Mayor's office	4. staff time	4. December 31, 2014

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Healthcare Transportation Meeting was scheduled and the group met
Healthcare transportation plan was developed

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Was legislation passed to increase local sales tax to support transportation for healthcare services?
Was the transportation plan implemented?
Is the community using the service?

Who is missing? *(What other agencies or organizations need to be included?)*

Jacksonville Transportation Authority, hospitals, transportation companies, clinicians in private practice, Jacksonville mayor's office, city council and consumers

Community Health Priority #3:
Improve Chronic Care Management

Strategic Objective 3.1:

Decrease percentage of emergency room visits due to ambulatory care sensitive conditions by 10% by December 31, 2015

Critical Action 3.1.2:

Provide mobile health services to the community

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Identify current services available	1. St. Vincent's Outreach & DCHD	1. staff time	1. September 30, 2012
2. Convene first Mobile Health Services group	2. St. Vincent's & Brooks Rehab	2. staff time	2. December 31, 2012
3. Expand current mobile services by covering more areas of Duval County	3. St. Vincent's and DCHD	3. grant funds, staff time	3. December 31, 2013
4. Purchase additional mobile units	4. St. Vincent's and DCHD	4. cost of mobile van, hire staff	4. December 31, 2014
5. Open more community clinics in neighborhoods	5. Hospitals and We Care	5. funds, staff time and volunteers	5. December 31, 2014

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Baseline data were established (# of mobile vans in the community, area of current coverage by van, # of neighborhood clinics, # of hour for neighborhood clinics)
Mobile van(s) were purchase
More community clinic sites were opened

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Was there an increase in the area covered by the mobile vans?
Was there an increase in neighborhood clinics and hours opened in the neighborhood clinics?

Who is missing? *(What other agencies or organizations need to be included?)*

Hospitals, clinicians in private practice, Health IT providers (telemedicine) and consumers, Volunteers in Medicine, We Care

Community Health Priority #3:
Improve Chronic Care Management

Strategic Objective 3.2:

Establish coordinated system for chronic care management and expansion clearinghouse by December 31, 2015

Critical Action 3.2.1:

Seek and apply for grants related to chronic care management

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Identify appropriate grants that are available	1. DCHD - IPHIR	1. staff time	1. December 31, 2012
2. Create a distribution list of chronic care management stakeholders	2. DCHD - IPHIR	2. staff time	2. June 30, 2013
3. Forward information to stakeholder group (Refer to Critical Action 3.2.3)	3. DCHD - IPHIR	3. staff time	3. June 30, 2013

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Establish baseline for number of grant opportunities and partnerships
DCHD staff designated to support critical action
Chronic care management distribution list created and maintained and grant information is being shared with the stakeholders

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Was there an increase in grant being submitted?
What was the number of grants that had community collaboration?
What was the number of successful grant applications?

Who is missing? *(What other agencies or organizations need to be included?)*

Community grant writers, St. Vincent's PATH program, HERAP, NEFL Health Planning Council

Community Health Priority #3:
Improve Chronic Care Management

Strategic Objective 3.2:

Establish coordinated system for chronic care management and expansion clearinghouse by December 31, 2015

Critical Action 3.2.2:

Include evidence-based methodologies in new grant applications and treatment protocols

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when? Month/day/yr</i>
1. TBD by December 31, 2013	1. TBD by December 31, 2013	1. TBD by December 31, 2013	1. TBD by December 31, 2013
Evidence of Success <i>(How will you know that you are making progress? What are your benchmarks?)</i> TBD by December 31, 2013			
Evaluation Process <i>(How will you determine that the goal has been reached? What are your measures?)</i> TBD by December 31, 2013			
Who is missing? <i>(What other agencies or organizations need to be included?)</i> TBD by December 31, 2013			

Community Health Priority #3:
Improve Chronic Care Management

Strategic Objective 3.2:

Establish coordinated system for chronic care management and expansion clearinghouse by December 31, 2015

Critical Action 3.2.3:

Create a clearinghouse to streamline and coordinate grant applications for chronic care management

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Approach NEFL Health Planning Council about being the area's Health Care grant clearinghouse	1. DCHD and United Way	1. staff time	1. September 31, 2012
2. Convene a Health Grant clearinghouse group	2. NE Florida Health Planning Council & DCHD	2. staff time	2. December 31, 2012
3. Establish funding to support expansion	3. NE Florida Health Planning Council	3. funds, staff time	3. December 31, 2013
4. Expand the NE Florida Counts function to include grant application	4. NE Florida Health Planning Council	4. staff time	4. January 31, 2014
5. Promote the use of clearinghouse	5. All	5. staff time	5. January 31, 2014

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Health Grant Clearinghouse Meeting was scheduled and the group met
Funding or in-kind services were found to support the expansion of NE FL Counts

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Was a clearinghouse for health-related (chronic care management) grants developed?
Is the clearinghouse being utilized by the community?
How often is the clearinghouse being used?

Who is missing? *(What other agencies or organizations need to be included?)*

NEFL Planning Council, private practice clinicians, community grant writers, hospitals

Community Health Priority #3:
Improve Chronic Care Management

Strategic Objective 3.2:

Establish coordinated system for chronic care management and expansion clearinghouse by December 31, 2015

Critical Action 3.2.4:

Develop and enhance relationships with public/private corporate sponsors

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Identify appropriated public/private sponsors	1. DCHD - PIO	1. staff time	1. September 30, 2012
2. Convene a Public/Private sponsors meeting	2. DCHD - PIO	2. staff time	2. December 31, 2012
3. Get commitments from public/private corporate sponsors.	3. DCHD - PIO	3. staff time	3. June 30, 2013
4. Funds allocated by public/private corporate sponsors	4. Corporate sponsors (TBD)	4. staff time, funds, resources (TBD)	4. December 31, 2013

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Establish baseline for number of public/private sponsors and values of resources allocated to chronic disease management
 Public/Private Sponsors Group Meeting was scheduled and the group met

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Was there an increase in public/private corporate sponsors for chronic care management?
 Was there an increase in resources allocated to chronic disease management?

Who is missing? *(What other agencies or organizations need to be included?)*

Private corporations, hospitals, health insurance, consumers

Community Health Priority #3:**Improve Chronic Care Management****Strategic Objective 3.3:**

Increase the proportion of persons with a usual primary care provider to 90% by December 31, 2017

Critical Action 3.3.1:

Develop referral service for health care systems users without a PCP

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Asset mapping (is there a referral system?)	1. DCHD & United Way	1. staff time	1. September 30, 2012
2. Convene first PCP Referral meeting	2. Northeast Florida Uninsured Workgroup	2. staff time	2. December 31, 2012
3. Identify local Patient Centered Medical Homes and Accountable Care Organization	3. Duval County Medical Society	3. staff time	3. December 31, 2012
4. Contract with medical homes and ACO	4. DCMS	4. staff time	4. December 31, 2013
5. Establish an electronic referral system	5. Northeast Florida Health Information Exchange	5. funds and use of local Health Information Exchange	5. December 31, 2015

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

PCP Referral Meeting was scheduled and the group met
A list of PC Medical Homes and ACO was developed
Contracts with PC Medical Homes and ACO were executed

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Was an electronic referral system created?
Is the electronic referral system being utilized?
How often is the electronic referral system being utilized?

Who is missing? *(What other agencies or organizations need to be included?)*

Primary care physicians, hospitals, other health service agencies, Medical Society, Florida Academy of Family Physicians, NEFHIE

Community Health Priority #4:
Enhance Communication within the Local Public Health System

Strategic Objective 4.1:

Create and communicate a formalized health system process to ensure continuity of care for Duval County residents by December 31, 2015

Critical Action 4.1.1:

MOA Development with key health system partners

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Develop and execute MOAs to facilitate transition	1. NEFHSC and partner agency staff	1. In-kind	1. May 31, 2013
2. Contact and Partner with JCCI to create an agreement for needs assessment	2. ECS	2. TBD by December 31, 2013	2. TBD by December 31, 2013
3. Facilitate communication and partnerships	3. ECS	3. TBD by December 31, 2013	3. TBD by December 31, 2013

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Number of MOAs developed
Increased provider, patient, faculty, staff, and student awareness of importance of communication for care coordination

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Increased partnerships and MOAs
Active working MOAs

Who is missing? *(What other agencies or organizations need to be included?)*

Community Health Priority #4:
Enhance Communication within the Local Public Health System

Strategic Objective 4.1:

Create and communicate a formalized health system process to ensure continuity of care for Duval County residents by December 31, 2015

Critical Action 4.1.2:

Conduct community meetings through focus groups, surveys, and dialogue to ensure that the system meets the needs of the community and will be easy for them to use

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Community meetings for the hospitals assessment	1. HPCNEF	1. HPCNEF and 9 non-profit hospitals	1. December 31, 2012 and ongoing
2. Conduct point staff training	2. NEFHSC and partner agency staff	2. Healthy Start	2. May 31, 2013
3. Conduct communication training	3. Center for Global Health at UNF	3. Sponsorships	3. At least biannually

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Completion of the community health needs assessments for hospitals and integration in CHIP

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Finalization of the health needs assessments and integration into CHIP
 Attendance in trainings and seminars
 Evaluation from trainings and seminars

Who is missing? *(What other agencies or organizations need to be included?)*

Community Health Priority #4:
Enhance Communication within the Local Public Health System

Strategic Objective 4.1:

Create and communicate a formalized health system process to ensure continuity of care for Duval County residents by December 31, 2015

Critical Action 4.1.3:

Enhance online community information sites and electronic health tools

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Determine subject matter experts to produce white papers on different subjects	1. HealthyJax staff and community partners in HealthyJax coalitions	1. RUCKUS, HealthyJax staff, JCCI, HPC, UNF, JU, FSCJ, EWC, and community leaders	1. December 31, 2012
2. Research opportunities to present on-line information off-line	2. RUCKUS, HealthyJax staff	2. RUCKUS	2. September 30, 2013
3. Track, measure, monitor, and evaluate impact of a consolidated health resource site	3. RUCKUS	3. RUCKUS	3. Ongoing
4. Identify partner organizations providing services needed by new and expectant families and provide link on websites	4. NEFHSC staff	4. In-kind	4. May 31, 2013 and ongoing

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Number of new links and website hits
Increased community collaboration

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Referrals between programs
Establishing a website and putting a process in place

Who is missing? *(What other agencies or organizations need to be included?)*

Other college and university departments

Community Health Priority #4:**Enhance Communication within the Local Public Health System****Strategic Objective 4.1:**

Create and communicate a formalized health system process to ensure continuity of care for Duval County residents by December 31, 2015

Critical Action 4.1.4:

Promote the use of NE FL Counts for sharing information regarding activities and opportunities

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Promote NE FL Counts through marketing: press releases, newsletter, e-blasts, etc.	1. HPCNEF – Rebecca Brosemer	1. HPCNEF and other Duval County health organizations	1. December 31, 2012 and ongoing
2. Social media plan for NE FL Counts connecting all Duval County health organizations	2. HPCNEF – Rebecca Brosemer and Susan Cohn	2. Susan is dedicated full-time to NE FL Counts with other organizations adding data	2. December 31, 2012 and ongoing
3. Identify organizations working with families after delivery (i.e. ELC, Headstart)	3. NEFHSC staff	3. In-kind	3. December 31, 2012
4. Hold annual public health conference to convene community around identified critical issues	4. UNF Brooks College of Health, Department of Public Health	4. Faculty and student sponsorships	4. Annually in July
5. Make an all-call through various media outlets	5. ECS - Holly	5. TBD by December 31, 2013	5. TBD by December 31, 2013

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Hits on new website, number of presentations, and number of white papers produced

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Active and engaged community on NE FL Counts website and social networks
Increased job satisfaction from participants

Who is missing? *(What other agencies or organizations need to be included?)*

Community Health Priority #4:
Enhance Communication within the Local Public Health System

Strategic Objective 4.2:

Create a dashboard to track progress towards meeting CHIP objectives by December 31, 2013

Critical Action 4.2.1:

Create dashboard where all partners can view progress towards objectives

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Create a linked dashboard to maintain up-to-date data automatically	1. Health Planning Council	1. In-kind	1. TBD by December 31, 2013

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Presence of dashboard with regularly updated data

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Assess number of goals being tracked

Who is missing? *(What other agencies or organizations need to be included?)*

United Way

Community Health Priority #4:
Enhance Communication within the Local Public Health System

Strategic Objective 4.3:

Increase the number of member organizations in the Partnership for a Healthier Duval from outside the health sector by 10% by December 31, 2013

Critical Action 4.3.1:

Encourage partners from inside the health sector to reach out to other organizations

Tasks/Action Steps <i>What will be done?</i>	Responsibilities <i>Who will do it?</i>	Resources <i>Funding/time/people/materials</i>	Timeline <i>By when?</i> <i>Month/day/yr</i>
1. Reach partners in the community	1. Healthy Families Jax	1. MOA	1. July 31, 2012
2. Establish community goals in a collaborative partnership	2. DCHD and Healthy Families Jax	2. TBD by December 31, 2013	2. August 31, 2012
3. Exchange information about services provided	3. Healthy Families Jax	3. Trainings and visual meetings	3. December 31, 2012
4. Reach out to citizen groups like CPACs and neighborhood associations to explain what's being done	4. COJ Planning department	4. TBD by December 31, 2013	4. TBD by December 31, 2013
5. Identify non-health-related sites through internships in employee health	5. UNF Brooks College of Health Faculty	5. Faculty and existing internship programs	5. Ongoing
6. Determine baseline of current number of members outside of health sector	6. DCHD PIO	6. Time/staff	6. September 30, 2012
7. Request current members to identify and contact non-members outside the health sector concerning membership	7. DCHD PIO	7. Time/staff	7. December 31, 2012
8. Record number of new members that are outside health sector	8. DCHD PIO	8. Time/staff	8. December 31, 2013

Evidence of Success *(How will you know that you are making progress? What are your benchmarks?)*

Increase patient (participant) knowledge about Health Department services and continue to be linked after graduating from the program

Increased partnerships with non-health-related organizations

Percentage increase in number of new members from outside the health sector from baseline

Evaluation Process *(How will you determine that the goal has been reached? What are your measures?)*

Number of families who have completed immunizations in a timely manner
Increased internship site partnerships across northeast Florida
Percentage increase in number of new members from outside health sector from baseline

Who is missing? *(What other agencies or organizations need to be included?)*

Collaboration with other colleges within campus

Appendix A: Participating Organizations

Aetna
American Association of Clinical Endocrinologists
American Cancer Society
American Dietetic Association
American Heart Association
American Lung Association
Area Health Education Center
Baptist Home Health Group
Baptist Hospital
Baptist Medical Center
Beaches Emergency Assistance Ministry
Blue Cross Blue Shield
BluePrint for Prosperity
Bob Hayes Foundation
Boys & Girls Club of Northeast Florida
Brooks Health System
Brooks Rehabilitation Hospital
Catholic Charities
Celebration Church
City of Jacksonville - Adult Services
City of Jacksonville - Children's Commission
City of Jacksonville - Planning Department
City of Jacksonville - Disabled Services
City of Jacksonville - Fire and Rescue
City of Jacksonville - Housing Authority
City of Jacksonville - Parks and Recreation
Clara White Mission
Community Connections
Community Planning & Advisory Council District 1: Urban Core
Community Planning & Advisory Council District 2: Greater Arlington/Beaches
Community Planning & Advisory Council District 3: Southeast
Community Planning & Advisory Council District 4: Southwest
Community Planning & Advisory Council District 5: Northwest
Community Planning & Advisory Council District 6: North
Community Resource Education Development
CSX Transportation
Duval County Cooperative Extension
Duval County Health Department - Chronic Disease
Duval County Health Department - Dental
Duval County Health Department - Environmental Health
Duval County Health Department - IPHIR
Duval County Health Department - Mental Health
Duval County Health Department - Institutional Medicine
Duval County Health Department - Maternal and Child Health

Duval County Health Department/City of Jacksonville Institutional Medicine
Duval County Medical Society
Duval County Public Schools - Special Programs
Edward Waters College
ElderSource
Episcopal Children's Services
Family Foundations
Florida State College at Jacksonville
Florida Department of Aging
Florida Department of Agriculture
Florida Department of Children and Families
Florida Department of Elder Affairs
Florida Department of Transportation
Florida Times-Union
Fresh Ministries
Gateway Community Services
H Magazine
Health Planning Council of Northeast Florida
Healthy Jax Coalition: Oral Health
Healthy Jax Coalition: Physical Fitness & Nutrition
Healthy Jax Coalition: Smoke Free Jacksonville
Healthy Jax Coalition: Asthma
Healthy Jax Coalition: Cancer
Healthy Jax Coalition: Childhood Obesity and Nemours
Healthy Jax Coalition: Diabetes
Healthy Jax Coalition: Environmental Quality
Hispanic Alliance
Hola News
Hubbard House
Independent Living Resource Center of Northeast Florida
IM Sulzbacher Center
Jacksonville Beach City Council
Jacksonville Chamber of Commerce
Jacksonville Community Council, Inc.
Jacksonville Electric Authority
Jacksonville Public Libraries
Jacksonville Sheriff's Office
Jacksonville Transportation Authority
Jacksonville University
Jaguar Foundation
JaxCare
Jessie Ball DuPont Foundation
Jewish Family and Community Services
Lutheran Social Services
Mayo Clinic
Mayor's Disability Council

Medicaid
Memorial Hospital
Mental Health America
NAS-JAX Naval Hospital
Nemours Children's Hospital
North Florida Community Action Agency
Northeast Florida Healthy Start Coalition
Northeast Florida Regional Planning Council
Planned Parenthood
Publix Supermarkets
River Region Human Services
Salvation Army
St. John's Cathedral
St. Luke's Hospital
St. Vincent's Hospital
St. Vincent's Mobile Health Unit
Susan G. Komen Foundation
UF & Shands Jacksonville
United Way
University of North Florida
Urban Jax
Volunteers in Medicine
We Care Jacksonville Clinics
Winn Dixie
Wolfson Children's Hospital
Youth Crisis Center

Appendix B: MAPP Instruments

CTSA Survey

The following information was collected through a community survey conducted in person and by mail.

Total Number of Community Residents Surveyed: _____

Date: _____

Quality of Life Questions	Likert Scale Responses (1 to 5, with 5 being most positive)
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.) [IOM, 1997]	
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	
4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need?	
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	
10. Are community assets broad-based and multi-sectoral?	
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments?	

Strategic Issue Worksheet

Strategic issues are the fundamental policy choices facing an organization's or system's vision, mandates, values, services, clients, resources, or operations.

1. Identify the strategic issue. Phrase the issue as a question. (Example: How can the health community ensure access to population-based and personal health care?)

2. Why is this an issue? What convergence of external opportunities and threats, system strengths and weaknesses, health status findings or community themes makes this an issue?

3. What are the consequences of not addressing this issue?

Strategic Issues Relationship Diagram

Relationship to Vision: _____



Appendix C: Goal Setting Exercise for Access to Health Care

Step 1 – Brainstorming Session

1. Distribute notes and pens to participants.
2. Ask the following questions (1 by 1 giving participants an opportunity to write their responses on the post-it provided):
 - a. What needs to happen to ensure that the residents of Duval County have access to health care?
 - b. Why do you think access to health care is lacking in Duval County?
 - c. How would you know there is access?
3. Ask each participant to write one response per sticky note
 - a. Write as many responses as you can (1 per sticky note)
 - b. Write all responses and do not filter your answers
4. Go to the space on the wall marked Access to Health Care, randomly place the sticky notes on the wall under that heading, and wait for everyone else to finish this activity
5. Without speaking, approach the wall and arrange the sticky notes into groups of similar statements. You can move someone else's note if you feel it fits better elsewhere. Review the wall until you are satisfied with the classifications. Once you are satisfied, please take your seat.
6. The facilitator will now read each of the groups of sticky notes aloud and ask the group to develop a "title" or "heading" that describes the content of the responses. All group members have to agree to the heading.
7. Consolidate the sticky note groupings into overarching categories.

Access to Healthcare Brainstorming Results:

Transportation/Location/Hours

- Inconvenient hours
- Expand JHIN to social services providers
- Inconvenient locations
- Some neighborhoods don't have health care providers close by
- Location and expansion for urgent cares
- Increased hours and weekend hours
- Location

Health Education/Health Promotion/Awareness

- Awareness
- Education as to what is available
- Lack of access and health education
- Need more health promotion
- Make health care less intimidating
- Education through TV, radio, and newspaper
- Communication, awareness, and knowledge of access
- People are not aware of what is available
- Educate clients after E.D. visit

- Children have health education at school
- Statistics of number of visits per population – compare to cities.
- Provide health education throughout .
- Provide health education
- Increase marketing of KidCare and Indigent care programs.
- Pool the community resources. Send information about health care through schools.
- Health Literacy increases so people know when and where to access care

Improve Health Outcomes

- Overall health of the community improves.
- Indicators (maybe school attendance higher?)
- Needs Assessment
- When indicators decreased
- Health outcomes would improve
- Less obesity and related illnesses (diabetes)

Funding for Health Department

- Medicaid expansion (through health care reform)
- Not enough funding for uninsured health care
- Insurance access increase
- LIP funding
- Need health reform to go through
- Encourage new We Care Jacksonville slots

Increase number of PCP's

- Specialty care
- Plenty of specialists insured PCP's
- Increased number of providers willing to take Medicaid

Adequate Reimbursement for Care

- Not enough funding for uninsured outside Shands Jax

Adequate insurance coverage

- Lack of insurance that is affordable
- Limited low income providers
- Low reimbursement
- Funding support
- Federal draw downs complete
- Primary care reimbursement
- Dental reimbursement increase

Increase safety net of providers outside of hospital

- We Care Jacksonville expansion

- Expanded use of Shands Jax – city revenue sharing money to non hospital community providers
- FQHC expansion
- Increased funding for FQHC's (federal clinics, DCHD, and Sulzbacher)
- Money to build
- Spread COJ funding of indigent care beyond Shands

Increase medical home model

- Expertise
- All people would have a medical home
- Patient's ID of medical home
- Reduced ER visits
- Improved chronic disease management
- Develop more ER diversion and alternatives
- More care alternatives
- Housing
- Less use of ER's for primary care
- More medical homes for uninsured (ER Diversion)
- The lines at FQHC would be shorter
- Expand amount of urgent care systems outside of hospitals
- Number of ER visits for non-admit reasons drops

Improve social determinants (unemployment, housing, etc.)

- Poor transportation
- Improved transportation
- Improve environment
- Improve, build environment
- Identify new funding opportunities for primary care
- Unemployment rate down
- Reduced ER utilization

Step 2 – Prioritizing our Goals

Give each participant 4 sticker dots to place next to the categories that he or she considers to be the most important. (You can place your dots in any manner you please such as one dot to each category or even 4 dots in one category)

The categories that receive the most votes are the prioritized goals for Duval County!

Step 3 - Goal Statements

Break into four small groups and assign each group one priority

Develop a goal statement under for each priority that will to guide our work to attain the vision.

Step 4- Create Strategies for Each Goal

Based on the goals statements, begin recording any possible strategies that could be used in achieving each goal. Ask the following questions:-

- Does this strategy attack the root cause?
- Is it a powerful method of change?
- Will the strategy distribute benefits widely in the community? (age, race, gender, income and disability)

Access to Care Goals

Goal 1

Improve the health literacy of Duval County residents.

Strategies:

1. Provide health education throughout the lifespan.
2. Provide marketing and resources.
3. Keep health issues in the public debate

Goal 2

Improve the social determinants of health for Duval County.

Strategies:

1. Improve environment: Built environment, sewers, walkable communities
2. Enhance education (high school graduation)

Goal 3

Ensure adequate and affordable insurance coverage for all Duval County residents.

Strategies:

1. Simplify application process for KidCare, Medicaid, and other indigent care programs.
2. Educate clients after emergency department visits on available programs.

Goal 4

Increase the number of safety net providers outside of hospitals

Strategies:

1. Ensure all HRSA NAP grants are applied for locally
2. Encourage private and hospital-based physicians to offer We Care Jacksonville slots.
3. Identify new funding opportunities for primary care.

Step 5 - Perform a SWOT Analysis

Evaluate the proposed strategies using Strengths-Weaknesses-Opportunities- Threats (SWOT) Analysis. Please refer to the SWOT handout for guidance.

Perform the SWOT analysis on as many strategies as you can in the allotted time. Once the SWOT analysis is complete, each small group will present their strategies to the entire room and each strategy will be voted on for adoption or rejection. Votes received are shown in parentheses below.

Goal 1

Improve healthy literacy in the Jacksonville Community

- A. (7) Provide health education throughout the life span
- B. Provide marketing and resources
- C. Keep health issues in the public debate

Goal 2

Improve Social determinants of health for Jacksonville and Community

- A. (2) Enhance education (high school, graduation, educational)
- B. Decrease unemployment
- C. (1) Avoid war
- D. (4) Improve environment
- E. Built environment
- F. Sewers
- G. Walkable communities

Goal 3

Ensure adequate and affordable insurance coverage for all Duval County residents

- A. (4) Simplify application process for KidCare, Medicaid, and other indigent care programs
- B. Lobby and advocate to Duval delegation to expand Medicaid coverage
- C. (1) Increase marketing efforts of Kidcare and other indigent care programs
- D. (2) Educate clients after emergency department visits on available programs

Goal 4

Increase number of safety net providers outside of hospitals

- A. (5) Ensure all HRSA NAP grants are applied for locally
- B. (1) Encourage private and hospital-based physicians to offer We Care Jacksonville slots
- C. (1) Identify new funding opportunities for primary care
- D. Fully utilize existing mobile units to collaborate with non-profit health entities

Step 6 – Accepted Strategies/Next Steps

We will collect all the approved strategies for each of the goals. The strategies with the most votes will be explored further for the development of the community action plan.

Glossary

ACS: American Community Survey. The ACS is conducted annually and asks many of the same questions found on official US Census surveys conducted every 10 years.

Ambulatory Care: A health consultation or treatment performed in an outpatient setting without the need for a hospital admission.

Behavioral Risk Factors: Risk factors in this category include behaviors that are believed to cause, or to be contributing factors to, most accidents, injuries, disease, and death during youth and adolescence as well as significant morbidity and mortality in later life. This is a category of data recommended for collection in the Community Health Status Assessment.

BRFSS: Behavioral Risk Factor Surveillance Survey. A national survey of behavioral risk factors conducted by states with CDC support.

Cause of Death: Any condition that leads to or contributes to death and is classifiable according to the International Classification of Diseases.

CDC: The Centers for Disease Control and Prevention. www.cdc.gov

Chronic Care Management: Oversight of patients with chronic diseases in order to coordinate care, reduce service duplications, and allow more efficient responses to acute events.

Communicable Disease: Measures within this category include diseases that are usually transmitted through person-to-person contact or shared use of contaminated instruments/materials. Many of these diseases can be prevented through the use of protective measures, such as a high level of vaccine coverage of vulnerable populations. This is a category of data recommended for collection in the Community Health Status Assessment.

Community: The aggregate of persons with common characteristics such as geographic, professional, cultural, racial, religious, or socio-economic similarities; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other common bonds (Adapted from Turnock's Public Health: What It Is and How It Works).

Community Assets: Contributions made by individuals, citizen associations, and local institutions that individually and/or collectively build the community's capacity to assure the health, well-being, and quality of life for the community and all its members.

Community Collaboration: A relationship of working together cooperatively toward a common goal. Such relationships may include a range of levels of participation by organizations and members of the community. These levels are determined by: the degree of partnership between community residents and organizations, the frequency of regular communication, the equity of decision making, access to information, and the skills and resources of residents. Community

collaboration is a dynamic, ongoing process of working together, whereby the community is engaged as a partner in public health action.

Community Health: A perspective on public health that assumes community to be an essential determinant of health and the indispensable ingredient for effective public health practice. It takes into account the tangible and intangible characteristics of the community – its formal and informal networks and support systems, its norms and cultural nuances, and its institutions, politics, and belief systems.

Community Health Improvement Process: Community health improvement is not limited to issues classified within traditional public or health services categories, but may include environmental, business, economic, housing, land use, and other community issues indirectly affecting the public's health. The community health improvement process involves an ongoing collaborative, community-wide effort to identify, analyze, and address health problems; assess applicable data; develop measurable health objectives and indicators; inventory community health assets and resources; identify community perceptions; develop and implement coordinated strategies; identify accountable entities; and cultivate community "ownership" of the entire process.

Community Partnerships: A continuum of relationships that foster the sharing of resources, responsibility, and accountability in undertaking activities within a community.

Community Support: Actions undertaken by those who live in the community that demonstrate the need for and value of a healthy community and an effective local public health system. Community support often consists of, but is not limited to, participation in the design and provision of services, active advocacy for expanded services, participation at board meetings, support for services that are threatened to be curtailed or eliminated, and other activities that demonstrate that the community values a healthy community and an effective local public health system.

Contributing Factors (Direct and Indirect): Those factors that, directly or indirectly, influence the level of a risk factor (determinant).

COPC: Childhood Obesity Prevention Coalition.

COPD: Chronic Obstructive Pulmonary Disease. A common lung disease which causes breathing difficulty and usually takes the form of bronchitis or emphysema.

Core Indicators: Data elements that MAPP recommends all communities collect and track. The core indicators have a higher priority based on the critical nature of the data, potential for comparative value, and relevance to most communities.

Death, Illness, and Injury: Health status in a community is measured in terms of mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease). Mortality may be represented by crude rates or age-adjusted rates (AAM); by degree of premature death (Years of Productive Life Lost or YPLL); and by cause (disease - cancer and

non-cancer or injury - intentional, unintentional). Morbidity may be represented by age-adjusted (AA) incidence of cancer and chronic disease. This is a category of data recommended for collection within the Community Health Status Assessment.

DCHD: Duval County Health Department. www.dchd.net

Demographic Characteristics: Demographic characteristics include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and subpopulations are located, and the rate of change in population density over time, due to births, deaths and migration patterns. This is a category of data recommended for collection within the Community Health Status Assessment.

Determinants (or Risk Factors): Direct causes and risk factors which, based on scientific evidence or theory, are thought to influence directly the level of a specific health problem.

Dialogue: The skillful exchange or interaction between people that develops shared understanding as the basis for building trust, fostering a sense of ownership, facilitating genuine agreement, and enabling creative problem solving.

ED: Emergency Department. The ED specialized in acute care of patients without prior appointments.

Environment: The totality of circumstances where individuals live, work, learn, and play.

Environmental Health: The interrelationships between people and their environment that promote human health and well-being and foster a safe and healthful environment.

Essential Public Health Services: A list of ten activities that identify and describe the core processes used in public health to promote health and prevent disease. The framework was developed in 1994. All public health responsibilities (whether conducted by the local public health agency or another organization within the community) can be categorized into one of the services.

Ethnicity: The classification of a population that shares common characteristics, such as religion, traditions, culture, language, and tribal or national origin.

Events: Forces of change that are one-time occurrences. Examples of events include the closing of a hospital, a natural disaster, or the passage of a piece of legislation.

Exposure: The amount of a stressor that an organism contacts over a certain period of time.

Forces: A broad all-encompassing category that includes trends, events, and factors.

Goals: Broad, long-term aims that define a desired result associated with identified strategic issues.

Health: A dynamic state of complete physical, mental, spiritual and social wellbeing and not merely the absence of disease or infirmity (WHO'S New Proposed Definition. 101st Session of the WHO Executive Board, Geneva, January 1998. Resolution EB101.R2).

Health Assessment: The process of collecting, analyzing, and disseminating information on health status, personal health problems, population groups at greatest risk, availability and quality of services, resource availability, and concerns of individuals. Assessment may lead to decision making about the relative importance of various public health problems.

Health Care Provider: A person, agency, department, unit, subcontractor, or other entity that delivers a health-related service, whether for payment or as an employee of a governmental or other entity. Examples include hospitals, clinics, free clinics, community health centers, private practitioners, the local health department, etc.

Health Problem: A situation or condition for people and their environment measured in death, disease, disability, or risk that is believed to persist in the future and is considered undesirable.

Health Promotion Activities: Any combination of education and organizational, economic, and environmental supports aimed at the stimulation of healthy behavior in individuals, groups, or communities.

Healthy Jax: Healthy Jacksonville Coalition to Prevent Childhood Obesity.

HRSA: The Health Resources and Services Administration. www.hrsa.gov

Health Resource Availability: Factors associated with health system capacity, which may include both the number of licensed and credentialed health personnel and the physical capacity of health facilities. In addition, the health resources category includes measures of access, utilization, and cost and quality of health care and prevention services. Service delivery patterns and roles of public and private sectors as payers and/or providers may also be relevant. This is a category of data recommended for collection within the Community Health Status Assessment.

Health Status Indicator: A single measure that purports to reflect the health status of an individual or defined group.

Healthy People 2020: “Science-based, 10-year national objectives for improving the health of all Americans managed by HHS. www.healthypeople.gov

Indicator: A measurement that reflects the status of a system. Indicators reveal the direction of a system (a community, the economy, and the environment), whether it is going forward or backward, increasing or decreasing, improving or deteriorating, or staying the same.

Infant Mortality Rate: A death rate calculated by dividing the number of infant deaths during a calendar year by the number of live births reported in the same year. It is expressed as the number of infant deaths per 1,000 live births.

Injury: Injuries can be classified by the intent or purposefulness of occurrence in two categories: intentional and unintentional injuries. Intentional injuries are ones that are purposely inflicted and often associated with violence. These include child abuse, domestic violence, sexual assault, aggravated assault, homicide, and suicide. Unintentional injuries include only those injuries that occur without intent of harm and are not purposely inflicted.

JCCI: Jacksonville Community Council, Inc. An organization seeking to engage people in order to change the community. www.jcci.org

KidCare: A state of Florida program offering health insurance for children from birth to age 18 even if one or both parents are working. www.floridakidcare.org

Local Health Department: An administrative or service unit of local or state government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than the state.

Local Public Health System: The human, informational, financial, and organizational resources, including public, private, and voluntary organizations and individuals that contribute to the public's health.

MAPP: Mobilizing for Action through Planning and Partnerships. A community-wide strategic planning process developed by NACCHO and CDC.

Maternal and Child Health: A category focusing on birth data and outcomes as well as mortality data for infants and children. Because maternal care is correlated with birth outcomes, measures of maternal access to, and/or utilization of, care is included. One of the most significant areas for monitoring and comparison relates to the health of a vulnerable population: infants and children. Birth to teen mothers is a critical indicator of increased risk for both mother and child. This is a category of data recommended for collection within the Community Health Status Assessment.

Morbidity: Illness or lack of health caused by infection, dysfunction, or injury. Most illnesses are not reportable to the board of health. Available morbidity data is often not population-based and is partially available from either public or private sources.

Mortality: A measure of the incidence of deaths in a population.

NACCHO: National Association of County and City Health Officials. www.naccho.org

NPHPSP: National Public Health Performance Standards Program. NPHPSP is designed to measure public health practices at the state and local levels. NPHPSP supports local, state, and government instruments for measurement. The local instrument, referred to as the local public health system assessment in MAPP, evaluates the capacity of local public health systems to conduct the 10 essential public health services. The NPHPSP is supported by a partnership of national organizations including, CDC, NNPHI, ASTHO, NACCHO, NALBOH, PHF and APHA. www.cdc.gov/od/ocphp/nphpsp/

Objectives: There are three types of objectives cited in MAPP: outcome objectives, impact objectives and process objectives.

Impact Objective: An impact objective is short term (less than three years) and measurable. The objects of interest are knowledge, attitudes, or behavior.

Outcome Objective: An outcome objective is long term (greater than three years) and measurable. The objects of interest are mortality, morbidity, and disability.

Process Objective: A process objective is short term and measurable. The object of interest is the level of professional practice in the completion of the methods established in a Community Health Plan. Process objectives may be evaluated by audit, peer review, accreditation, certification, or administrative surveillance. Objects of evaluation may include adherence to projected timetables, production, distribution, and utilization of products, and financial audits.

Personal Health Services: Services provided to individuals, such as those provided by local health department maternal and child health programs.

Public Health: (many alternatives) "...the science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of the social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health" (C.E.A. Winslow). The mission of public health is to fulfill society's desire to create conditions so that people can be healthy (Institute of Medicine, 1988).

Public Health Director/Local Health Director, Local Health Official: The person responsible for the total management of the health department. This person is appointed by the governing authority, often the board of health. The public health director is responsible for the day-to-day operations of the health department and its component institutions, often sets policy or implements policies adopted by the board of health, and is responsible for fiscal and programmatic matters.

Public Health Services: The provision of services to fulfill the mission of public health in communities. See Essential Public Health Services.

Public Participation: The involvement of citizens in governmental decision-making processes. Participation ranges from being giving notice of public hearings to being actively included in decisions that affect communities. See community collaboration.

Quality of Life: A construct that "connotes an overall sense of well-being when applied to an individual" and a "supportive environment when applied to a community" (Moriarty, 1996). While some dimensions of quality of life can be quantified using indicators that research has

shown to be related to determinants of health and community-well being, other valid dimensions of QOL include the perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life. This is a category of data recommended for collection within the Community Health Status Assessment.

Risk Assessment: The scientific process of evaluating adverse effects caused by a substance, activity, lifestyle, or natural phenomenon. Risk assessment is the means by which currently available information about public health problems arising in the environment is organized and understood.

Risk Communication: An interactive process of sharing knowledge and understanding so as to arrive at well-informed risk management decisions. The goal is a better understanding by experts and non-experts alike of the actual and perceived risks, the possible solutions, and the related issues and concerns.

Risk Factors: See Determinants.

Risk Management: The goal of risk management is to direct limited available resources to those areas and strategies where the greatest amount of risk can be reduced for the least amount of resources. In that "greatest risk" can be defined in a number of different ways, it is a value-laden process.

Socioeconomic Characteristics: Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education, and employment, and the proportion of the population represented by various levels of these variables. This is a category of data recommended for collection within the Community Health Status Assessment.

Social and Mental Health: This category represents social and mental factors and conditions which directly or indirectly influence overall health status and individual and community quality of life. This is a category of data recommended for collection within the Community Health Status Assessment.

Stakeholders: All persons, agencies and organizations with an investment or 'stake' in the health of the community and the local public health system. This broad definition includes persons and organizations that benefit from and/or participate in the delivery of services that promote the public's health and overall well-being.

Strategic Planning: A disciplined effort to produce fundamental decisions and actions that shape and guide what an organization (or other entity) is, what it does, and why it does it. Strategic planning requires broad-scale information gathering, an exploration of alternatives, and an emphasis on the future implications of present decisions. It can facilitate communication and participation, accommodate divergent interests and values, and foster orderly decision-making and successful implementation.

Strategies: Patterns of action, decisions, and policies that guide a group toward a vision or goals. Strategies are broad statements that set a direction. They are pursued through specific actions,

i.e., those carried out in the programs and services of individual components of the local public health system.

Surveillance: The systematic collection, analysis, interpretation, and dissemination of health data to assist in the planning, implementation, and evaluation of public health interventions and programs.

Sustainability: The long-term health and vitality — cultural, economic, environmental, and social — of a community. Sustainable thinking considers the connections between various elements of a healthy society, and implies a longer time span (i.e., in decades, instead of years).

Values: The fundamental principles and beliefs that guide a community-driven process. These are the central concepts that define how community members aspire to interact. The values provide a basis for action and communicate expectations for community participation.

Vision: A compelling and inspiring image of a desired and possible future that a community seeks to achieve. Health visions state the ideal, establish a 'stretch,' link explicitly to strategies, inspire commitment, and draw out community values. A vision expresses goals that are worth striving for and appeals to ideals and values that are shared throughout the local public health system.

Vital Statistics: Data derived from certificates and reports of birth, death, fetal death, induced termination of pregnancy, marriage, (divorce, dissolution of marriage, or annulment) and related reports.

YRBS: Youth Risk Behavior Survey. A self-administered, anonymous survey that was conducted in high schools and middle schools in Duval County during the spring of 2009 and 2011. The survey covers four general health risk areas: (1) violence, suicide, and safety; (2) alcohol, tobacco, and other drug use; (3) sexual behaviors; and (4) physical activity and dietary behaviors.